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Volume XXX, No. 1

Contents Page 7



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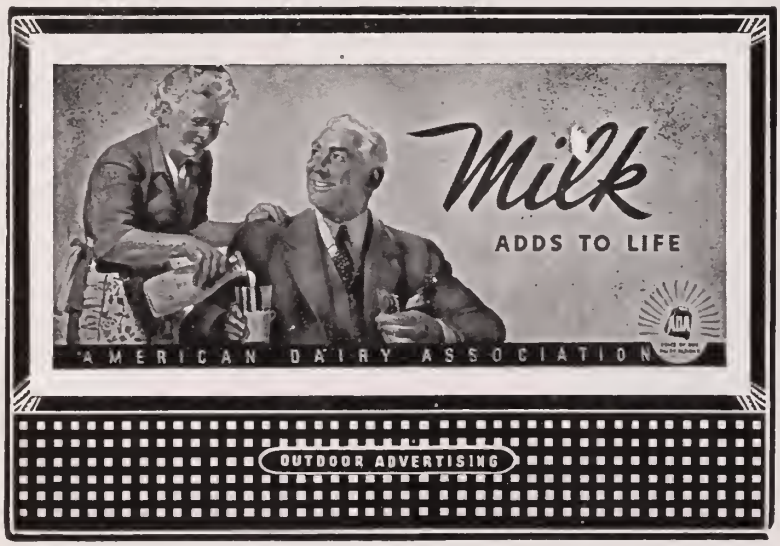
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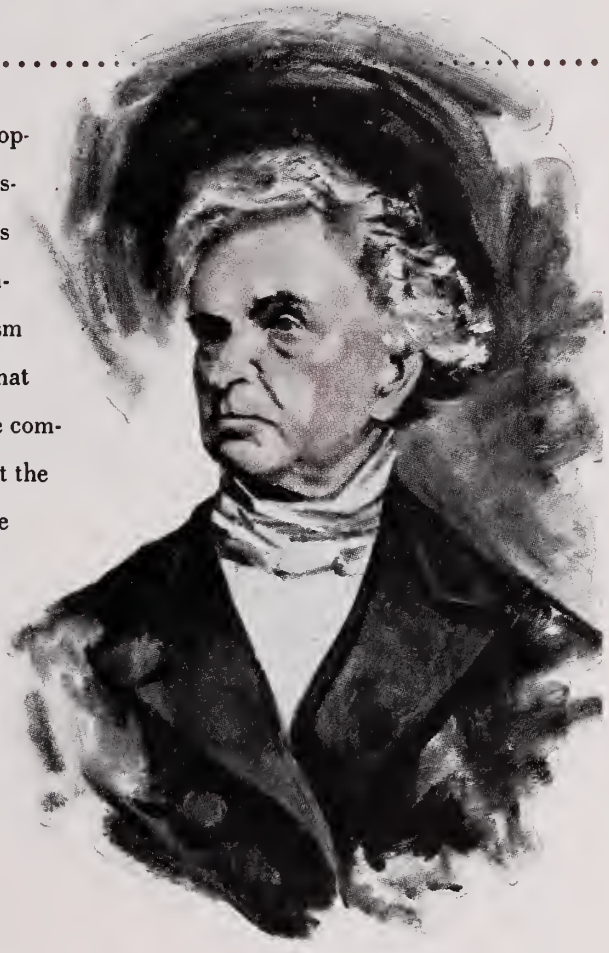
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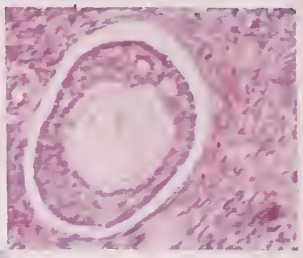
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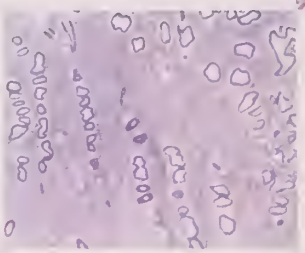


Color photomicrograph of section of ovary showing corpus luteum.

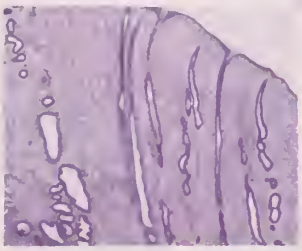
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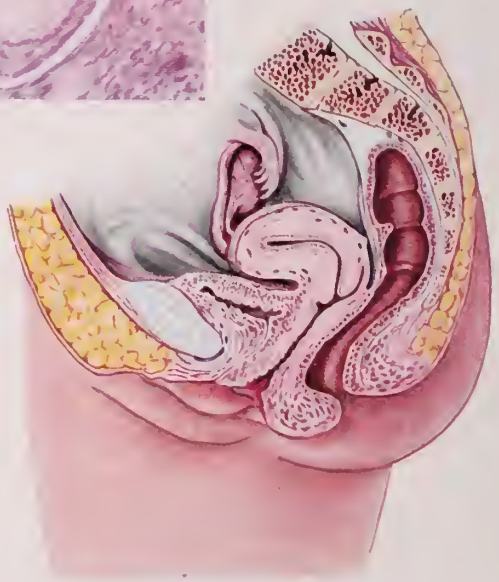
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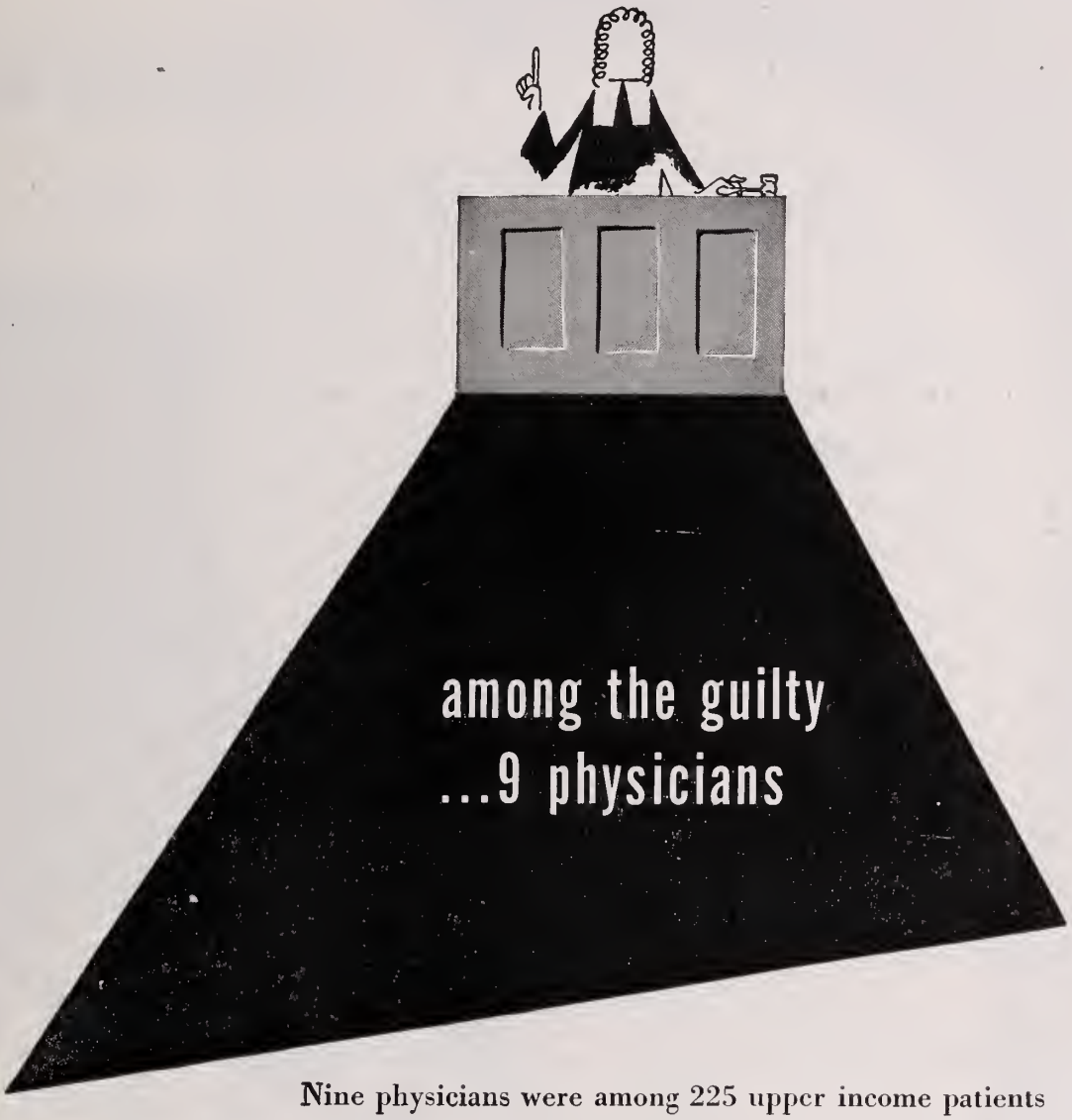
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXX JANUARY, 1947 NO. 1

PRIMARY BRONCHOGENIC CARCINOMA*

A Report of 47 Cases

JOSEPH N. CORSELLO, M.D. and WILLIAM B. O'BRIEN, M.D.

The Authors. *Joseph N. Corsello, M.D., of Providence. Former Assistant Superintendent, State Sanatorium. William B. O'Brien, M.D., of Wallum Lake. Acting Assistant Superintendent, State Sanatorium.*

IT IS ESTIMATED that primary bronchogenic carcinoma now causes approximately 15,000 deaths[1] annually in this country. There is widespread agreement that the incidence of this disease is increasing. Statistics based upon routine autopsy studies[2, 3] prove beyond doubt that this increase is absolute and not merely relative. From 8 to 10% of all cancer cases reported are said to be of this type, and in comparison with other organs primary carcinoma of the lungs is second in frequency only to cancer of the stomach. Indeed, it now threatens to surpass the latter.

A generally acceptable explanation for the increased incidence of the disease is lacking. It has been suggested that the use of tobacco[4] may be an important factor since an accelerated rate of cigarette consumption has paralleled the rising morbidity of bronchogenic carcinoma. Note also must be taken of the fact that vital statistics show the average span of life has lengthened, which has resulted in a larger number of living persons in the susceptible age groups. Occupation apparently has played no important role.

Primary bronchogenic carcinoma is essentially a disease of the 5th, 6th, and 7th decades of life, the great majority occurring in these age groups. Males predominate over females in a ratio of about 4 to 1, a fact which is not easily explainable.

From a pathological standpoint it is universally agreed that this type of neoplasm always arises in the basal membrane of the bronchial mucosa and never from the alveolar epithelium. Three main types have been classified—namely, (1) squamous-celled or epidermoid, (2) adenocarcinoma, and (3) the small-celled, oat-celled, or undifferentiated. It is believed that varying degrees of metaplasia account for the different types noted. The undifferentiated carcinoma is the most malignant and metastasizes very early. Adenocarcinomas and epidermoids show proportionately lesser degrees of malignancy in the order given. Squamous-celled cancers at times are very slow growing and a number of cases[5, 6] have been reported that survived up to 8 years without treatment.

These neoplasms may spread (1) by direct extension, (2) (3) through the lymph and blood channels, and (4) to other portions of the bronchial tree by means of air borne emboli. Lymphatic dissemination is the most common method and has been observed in over 70% of the patients reported. The liver becomes involved in about 30% of all cases. The kidneys and adrenals are also common sites of metastatic lesions.

Roughly 80% of the growths originate in the trachea or major bronchi, a fact of diagnostic and prognostic importance. Lesions in these sites tend to produce earlier local symptoms than those more peripherally located, usually are slower growing, metastasize later, and the great majority are accessible bronchoscopically. The right lung generally has been found to be more frequently involved than the left.

The present report is based upon 47 cases of primary bronchogenic carcinoma observed at the Rhode Island State Sanatorium during the period between 1933 and August 1946. All but one of these were diagnosed ante-mortem, and 41 (87.2%) were histologically confirmed. The latter consisted of 23 epidermoids (20 males, 3 females), 14 adenocarcinomas (12 males, 2

continued on next page

* Presented before the Providence Medical Association, at Providence, December 2, 1946.

females), 1 undifferentiated (female), and 3 unclassified (all males).

The group was comprised of 41 male and 6 female patients, a larger than usual ratio of males over females. The youngest was 18 and the eldest 79 years old. Table I shows the distribution according to age groups. It will be noted that 91.4% were between 40 and 69 years old. The average male age was 55.1 and the female 40.3 years.

Table II indicates the location of the points of origin of the neoplasms. The left lung was the site of initial growth very slightly more frequently than the right (51% to 48.9%). Considered individually, the left upper lobe was conspicuously more frequently involved than any of the others. Because of the relatively small number of cases we do not feel that any special significance should be attached to this fact and are merely reporting it as an interesting observation.

The diagnoses with which these patients had been labelled just prior to sanatorium admission were as follows: pulmonary tuberculosis in 24 (51%), diagnosis deferred in 18, idiopathic pleurisy with effusion in 2, unresolved pneumonia in 2, and "cold" in 1. In all, 5 patients actually

TABLE I

Age Distribution

Under 20	1 (2.1%)	
20 - 29	0	
30 - 39	2 (4.2%)	
40 - 49	13 (27.6%)	91.4%
50 - 59	18 (38.2%)	
60 - 69	12 (25.5%)	
70 - 79	1 (2.1%)	
Average Age Females	40.3 years	
Average Age Males	55.1 years	

TABLE II

Primary Sites of Lesions

Right Lung		*Left lung*	
Upper lobe	7 (14.8%)	Upper lobe	13 (27.6%)
Lower lobe	5 (10.6%)	Lower lobe	7 (14.8%)
Mid-lobe	2 (4.2%)	Main bronchus	4 (8.5%)
Main bronchus	7 (14.8%)		
Lobe undetermined	2 (4.2%)		
Total	23 (48.9%)		24 (51 %)

presented evidence of pulmonary tuberculosis, only one of whom, however, manifested clinical activity. Of the entire group the possibility of neoplastic disease was suspected by the referring physician in only 7 (14.8%).

The procedures which were utilized in arriving at the ultimate diagnosis were the clinical history, physical examination, laboratory studies, roentgen examinations (including laminography and bronchography in a few cases), bronchoscopy, and exploratory thoracotomy. Aspiration biopsy was not employed. This measure is now looked upon with disfavor in most quarters.[1, 4, 7]

Wide variations were noted with regard to the symptoms presented by these patients, and no clear cut pattern was observed which could be considered pathognomonic for this disease. With few exceptions, the symptoms began very insidiously and in most instances the time of onset could only be determined with but relative accuracy. In 3 cases it was utterly impossible even to guess when the first symptoms developed. In the majority the earliest symptoms noted were of thoracic origin, but in 12 they were extrathoracic. The latter usually consisted of easy fatigue, weakness, and loss of weight. Two patients first consulted their physicians because of pelvic pain, in one of whom the complaint was due to a metastatic lesion and in the other was caused by a urological condition not concerned with the bronchogenic carcinoma found. The drastic symptoms of hemoptysis was the initial warning sign in only 3 patients, although it was noted more frequently in later stages of the disease. In Table III are listed the frequency of

TABLE III

Frequency of Symptoms

Weight loss	46 (97.8%)
Loss strength	43 (93.4%)
Cough	43 (93.4%)
Expectoration	36 (76.5%)
Chest pain	36 (76.5%)
Hemoptysis	28 (59.5%)
Fever	27 (57.4%)
Dyspnoea	26 (55.3%)
Anorexia	18 (38.2%)
Hoarseness	7 (14.8%)
Wheeze	6 (12.7%)
Fatigue	4 (8.5%)

symptoms reported. Weight loss, weakness, cough, expectoration, chest pain, blood spitting, fever, and dyspnoea were the most common. However, as an initial symptom, cough greatly outstripped the others (Table IV). In the beginning the cough was usually dry, becoming productive, as a rule, in from several weeks to a few months. At this stage the condition was frequently mistaken for an ordinary respiratory infection according to the histories obtained.

Generally speaking, symptoms such as fever, anorexia, loss of weight and strength, and dyspnoea were late manifestations, occurring after the disease had become extensive and/or complicated by such developments as major bronchial obstruction, lung suppuration, and metastasis. Most patients exhibited a weight loss averaging between 20 and 30 lbs. by the time the lesion was well established. Fever usually was of a low-grade type, rarely exceeding 101°. Large hemoptysis was very infrequent, blood streaking which tended to be repetitious being the rule. Chest pain generally was dull, aching in nature and was apt to be more or less constant, though varying in severity. Dyspnoea was commonly rather mild even in the presence of

marked pathology, although a very few did manifest severe shortness of breath. The latter was particularly true of those with pleural effusions.

From a diagnostic standpoint physical examination proved to be of limited value. It was chiefly useful in uncovering distant metastatic foci in a few cases. In 3 such instances biopsy tissue obtained from these sources provided the means for proving the diagnosis. One case each of recurrent laryngeal nerve paralysis, Horner's syndrome, and brachial plexus involvement was also observed.

TABLE IV

Initial Symptoms

Cough	29 (61.7%)	Alone	9 (19.1%)
Expectoration	9 (19.1%)		
Loss strength	8 (17.3%)	Alone	3 (6.3%)
Chest pain	7 (14.8%)	Alone	2 (4.2%)
Weight loss	5 (10.6%)	Alone	2 (4.2%)
Fatigue	4 (8.5%)	Alone	1 (2.1%)
Hemoptysis	3 (6.3%)		
Fever	2 (4.2%)		
Pelvic pain	2 (4.2%)	Alone	1 (2.1%)
Dyspnoea	1 (2.1%)		
Hoarseness	1 (2.1%)		
Undetermined	2 (4.2%)		

Chest signs varied widely depending largely upon the stage of disease and the presence of secondary manifestations. A few patients presented no abnormal findings at all, but the majority showed many deviations from normal. A critical review of the chest signs found revealed no single findings or combination which could truly be termed to be peculiar to this disease alone. These findings differed in no way from those commonly noted in other chronic chest diseases. The one abnormal sign to which much significance is usually attached is a unilateral wheeze, which results from encroachment of the bronchial lumen by the tumor mass. This has been observed fairly frequently by other[7, 8] but was present in only 6 (12.7%) of these cases. Rales generally were less numerous than might have been expected, considering the degree of pathological changes revealed by the X-ray.

Laboratory studies proved of inestimable value both from the standpoint of pinning down the diagnosis microscopically and in ruling out other suspected conditions. As previously mentioned, 41 cases or 87.2% were histologically confirmed. In the remaining 6 the diagnosis was based upon clinical evidence which was deemed to admit of no serious doubt.

Bronchoscopy provided 18 positive bronchial tissue biopsies and 1 positive bronchial secretion cell block. In the latter instance a tissue specimen was also obtained but proved to be negative for cancer cells. This experience points up the value of examining secretions as well as tissue. Herbut and Clerf[9] recently have given considerable emphasis to this type of investigation. In 30 of their cases secretions obtained bronchoscopically yielded 73% positive results compared with only 36% from biopsied tissue. Postmortem examination was the source of positive tissue in 12 cases (25.5%), while exploratory thoracotomy yielded an additional 6 (12.7%). Reference has already been made to the 3 positive biopsies of distant metastatic lesions, and 1 other was proved by a cell block of aspirated pleural fluid. Thus a total of 29 (61.7%) cases were microscopically proved while the patients were still living. In no instance were we able to find cancer cells in the sputum, although many specimens were examined.

A great majority of the patients had secondary anemia, which generally was mild to moderate in severity. Profound reduction of hemoglobin and red cells was rare. A few patients with neoplasms of low grade malignancy who had suffered but little constitutional impairment showed normal blood pictures.

X-ray examination of these patients yielded much information that was of value both diagnostically and prognostically. We were unable to establish an absolute diagnosis through this medium alone, but the roentgenographic findings often directed the course of further investigation by pointing the finger of suspicion towards neoplastic disease. Considered as a whole, the findings were remarkable because of the variety of shadows which the lesions cast on the X-ray film. These ranged from discrete mottling to sizable, dense areas of rather uniform intensity. Mottled lesions of limited extent tended to be most confusing particularly when present in an upper lobe because of their similarity to tuberculosis infiltration. The one case missed was of this type, and, to compound the confusion, the patient had sputum positive for tubercle bacilli and a destructive lesion of the right sacro-iliac joint, which consultative opinion held was due to tuberculosis. At autopsy the latter was found to be the result of metastatic carcinoma involvement.

Lesions which were manifested as a more or less homogeneous dense mass, as a rule, were rather poorly circumscribed, the margins tending to be somewhat hazy and indefinite. Exceptions were noted in those cases in which an entire lobe was involved and the margin of the lesion was marked off by an interlobar fissure. The amount of lung involvement ranged from part of a lobe up to an entire lung. Three cases had bilateral involvement due to metastatic extension. Centrally located tumors manifested themselves either as a thickening of the hilum structures or as fairly discrete rounded masses projecting from the lung root out into the adjacent pulmonary field. Fan-shaped shadows considered to be characteristic of lobular atelectasis were noted in 2 cases. Changes due to

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secondary infection and atelectasis obscured the picture, and it was usually impossible to determine where the primary lesion began and left off. Seven cases showed evidence of cavitation, and in 4 others there was massive pleural effusion which concealed the underlying pulmonary pathology. In 2 patients invasion of the chest wall was revealed by X-ray evidence of rib destruction.

Sectional radiography and bronchography were valuable investigational adjuncts in a few cases in whom bronchoscopy yielded inadequate information. The laminagrams in each instance provided more precise information regarding the size and extent of the tumor than was obtained from conventional X-rays. In one case the laminagrams clearly revealed a narrowed, distorted bronchus which was not visible bronchoscopically. This finding was considered to be of neoplastic significance.

Bronchography was performed in 6 patients. This form of examination was chiefly valuable in graphically demonstrating bronchial obstructions, particularly those beyond the range of the bronchoscope.

Of all the methods of investigation employed, exclusive of microscopic examination, bronchoscopy was without peer as a means of obtaining a positive diagnosis. A total of 39 patients were examined in this manner. It has already been noted that in 19 of these a positive histological diagnosis was obtained, representing 48.3% of the number bronchoscoped. Of the other 20, in 10 bronchoscopy was essentially negative, while in the remaining 10, abnormalities were found which were deemed sufficient to warrant a clinical diagnosis. If these latter 10 are added to the 19 microscopically proved, we have a total of 29 patients in whom bronchoscopy provided either a confirmed or clinical diagnosis. This amounts to 74.3% of the total bronchoscoped or 61.7% of the entire series. Eight patients were not bronchoscoped because of the following reasons: condition too poor—5, diagnosis established by biopsy of metastatic lesion—1, lesion considered to be beyond range of bronchoscope—1, carcinoma unsuspected—1.

In addition to its use as a diagnostic measure, bronchoscopy was also a valuable aid in determining the operability of these cases. Evidence of inoperability fell under 2 headings—(1) local direct extension of the neoplasm to an unresectable portion of the tracheobronchial tree and (2) extensive paratracheal lymph node involvement as indicated by marked fixation of the trachea and noticeable broadening as well as loss of mobility of the carina.

Exploratory thoracotomy was recommended in 17 (36.1%) patients and was actually performed in 14, 3 refusing consent. Five, when explored, were found to be unresectable and 9 (19.1%) underwent total pneumonectomy. No partial resections were done. Two of the pneumonectomy cases died on the 2nd postoperative day, while all five that were merely explored survived the immediate operation with no ill effects. Four others of the resected patients died of recurrences or metastases 3 months, 5 months, 5 months, and 7 months, respectively, after the operation. Three are still alive, the longest for a period of 7 years and 7 months up to the time of this writing. The others have survived, respectively, for 3 years 1 month, and 1 year 9 months. Thus far none of these has manifested any signs of recurrence or metastasis.

In all, 41 patients, or (87.2%) of the total, are now known to be dead. Contact has been lost with one patient who was explored in March 1945 and was found to be unresectable. It is reasonable to suppose that this man is now probably deceased. Besides the 3 pneumonectomy survivals two others are still living, both of whom have only recently been diagnosed. One of these is to be explored soon. The other was found to have tracheal involvement and so was considered to be inoperable. An ultimate fatal termination appears to be certain in this case. Exclusive, then, of the patient awaiting exploration, the maximum that can be hoped for is a total net salvage of only 3 cases, or 6.3% of the entire group. Of the 3 pneumonectomy survivals 2 had epidermoids and one an adenocarcinoma.

Roentgen-ray treatment was given to several of the inoperable cases, but in no instance did it result in any appreciable benefit. This is in keeping with most reports from other quarters. Most authorities agree that X-ray therapy is without curative value in bronchogenic carcinoma.

The average duration of life from the time that the first symptoms were noted of the known dead was 17.3 months. This does not include 3 cases in whom the histories were inadequate. Five patients lived for only 3 months. The longest known survival period was 33 months. Four patients died between the 3rd and 6th month, for a total of 9 who failed to live longer than 6 months after the disease first manifested itself symptomatically. On the other hand, 7 survived for 24 or more months. The average duration of life for 15 patients with epidermoids whose histories were reasonably accurate was 13.5 months. For 12 adenocarcinoma cases it was 10.8 months and for 3 with unclassified neoplasms 19.5 months. The one with an undifferentiated type lived for 9 months after the onset of symptoms.

The figures just presented relating to mortality and average duration of life compare well with reports from other sources. They tend to corroborate the conclusion that this is a highly fatal disease even under the best of present day circum-

stances. Untreated this affliction results in 100% mortality. During the past decade thoracic surgery has provided reasonably safe means for dealing curatively with this disease, but in spite of this the fatality rate has remained appallingly high. Reports from different surgical clinics show that the maximum net salvage that has been obtained in any group of cases has been around 19%[4], with others showing similar results in from 8 to 13%[7,10]. Thus we may say that primary bronchogenic carcinoma still destroys up to 90% of its victims in an average of between 1 and 1½ years after the onset of symptoms despite new advances in diagnosis and treatment. The reason for this is, of course, that too many patients reach the thoracic surgeon too late for curative treatment. Any disease which can kill such an overwhelming precentage of its victims when means for its cure are available surely constitutes a serious challenge. It must be obvious that the manner in which this problem is being met has fallen far short of the mark. We well might ask ourselves why we are failing to cope with it more adequately.

With this objective in mind, the case histories obtained from these patients were reviewed. In 44 the histories were considered to be reasonably accurate. Information was sought regarding the time factor between the onset of the initial symptom and the patient's first visit to his doctor, his earliest X-ray and the establishment of the correct diagnosis, respectively. It was found that:

1. Twenty-four, or 54.5%, of these patients sought medical advice within 1 month of the first symptom, 5 within 2 to 3 months, 4 in from 3 to 6 months, 4 in from 6 to 12 months, and 7 others in from 1 to 2 years. The average was 4.2 months.

2. In contrast to the above, only 6 (13.6%) were X-rayed within 1 month of the initial symptom, 13 within 2 to 3 months, 8 in from 3 to 6 months, 5 in from 6 to 12 months, and 12 in from 1 to 2 years. The average was 7.6 months.

3. No patient was correctly diagnosed within 2 months of the first symptom and only 2 (4.5%) in less than 3 months. Twelve were diagnosed in from 3 to 6 months, 11 in from 6 to 12 months, 14 in from 1 to 2 years, and in 5 the interval was over 2 years. The average was 12.4 months.

An analysis of the above figures reveals several informative facts. First, a majority of the patients sought medical advice immediately following the appearance of symptoms or shortly afterwards, although many were grossly negligent in this respect. Secondly, most of the physicians first consulted showed an unfortunate tendency to delay unduly in setting in motion proper investigational machinery. This is indicated by the average lag of 34 months between the time of the patient's first visit to a doctor and his initial X-ray. Thirdly, a lack of sufficient consciousness in the minds of the doctors regarding the possibility that this disease might be present must be presumed to have existed, since there was an average delay of 8.2 months between the time of the initial visit and the establishment of the correct diagnosis. This is further supported by the fact that in only 15% of the group was pulmonary carcinoma suspected by the referring physician prior to sanatorium entry.

The record, then, is one of delay compounded upon delay and must be accepted as, at least, offering a partial explanation of why so few patients were diagnosed when the disease was still in a resectable stage. Further recourse to the histories reveals that the chief reason for delayed diagnoses lay, in most cases, in the mildness of the earliest symptoms. These were frequently mistaken for ordinary respiratory infections, and not only the patient but too often his physician were prone to view them with no great alarm. Where the symptoms persisted or became worse, there appeared to be too great a tendency to classify many of these patients as tuberculosis despite the fact, and we regret having to report so, that the majority had not had the benefit of sputum examination. The inference, then, should be clear. Respiratory symptoms in patients over the age of 40, particularly in males, should not be passed off lightly, especially if they continue unduly long. Caution should be exercised before making a diagnosis of tuberculosis in the absence of a positive sputum. Unless the symptoms can be quickly and properly accounted for, the possibility of bronchogenic carcinoma should be considered, and steps either to prove or rule it out undertaken promptly.

While procrastination and indecision undoubtedly have played conspicuous roles in the continued high mortality of the disease, we feel that there is another factor of importance which must be considered. It will be recalled that 5 patients failed to survive beyond the 3rd month following the initial symptoms and 4 others died within 6 months. In contrast to this, 7 patients, exclusive of the pneumonectomy survivals, lived for 2 years and longer. It is generally conceded that the undifferentiated bronchogenic carcinoma offers practically no hope for cure because of its extreme malignancy. We failed to find in the literature even one single authenticated instance of this type ever having been successfully treated. If such has ever been reported, it has escaped our notice. Of the 9 who failed to survive beyond the 6th month, 7 had either adenocarcinomas or epidermoids, types which have proved amenable to curative surgery.

It seems to us to be somewhat paradoxical that the same disease can produce early death in some, while in others the survival period may be 4 or more times longer. The explanation for this must

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rest, at least in part, upon the manner of evolution of these neoplasms in different individuals. The subclinical phase during which the tumors start and develop apparently is widely variable in duration. In many it appears to be so long that the neoplasms have already passed beyond the curable stage by the time the first warning sign is manifested. If this is true, and there is good reason to believe it is, then our ability to reduce the present mortality rate is definitely limited no matter how proficient we become diagnostically. To what extent we are so limited cannot, of course, be estimated. There can be no serious doubt, however, of the advantage to be gained by discovering these tumors while they are still preclinical. Means must be found for accomplishing this before any appreciable inroads can be made on the fatality rate of the disease. Fortunately, an aid to this end already is available in this country. We refer to the tuberculosis case-finding machinery, which even now is being further expanded. The roentgenograms of all individuals over 40 included in tuberculosis surveys should be particularly scrutinized for shadows suggestive of neoplastic disease. Furthermore, we are of the opinion that routine X-ray examination of all persons over 40 years of age, at least once annually, would constitute a meritorious policy.

Summary

1. Forty-seven cases of primary bronchogenic carcinoma are reported. Forty-one were males, 6 were females, and 91% were between 40 and 69 years old.
2. All but one were diagnosed before death, and 41 were histologically confirmed. Sixty-two per cent were microscopically proved while still living. These were accounted for as follows: 18 bronchial tissue biopsies, 1 bronchial secretion cell block, 6 by tissue obtained by exploratory thoracotomy, 3 biopsies from metastatic lesions, and 1 pleural effusion cell block.
3. The symptoms and physical findings were highly variable and were of little or no specific diagnostic value.
4. Roentgenographic examination and bronchoscopy proved to be the most fruitful aids to diagnosis, particularly the latter. Bronchoscopy was also of considerable value in determining operability of the cases.
5. Fourteen patients were explored surgically, and 9 underwent total pneumonectomy. Two of the latter died on the second post-operative day, and four others died less than seven months later of recurrences and metastases.
6. Forty-one patients are known to be dead. One other, lost track of, must also be presumed to be dead. Three (6.3%) have survived after pneumonectomy without evidence of recurrence or metastasis as yet. Two others are still alive, though one has unresectable disease. The other is shortly to be surgically explored.
7. The average duration of life for 38 of the known dead from onset of symptoms to fatal termination was 17.3 months.
8. A majority of the patients sought medical care immediately after the onset of symptoms or shortly afterwards, yet there was an average time lapse of 8.2 months between the patients' first visit to a doctor and the correct diagnosis.
9. The earliest symptoms of bronchogenic carcinoma in these cases were commonly mistaken for ordinary respiratory infections. In later stages the condition was erroneously diagnosed as pulmonary tuberculosis in over 50% of the patients. Only 15% were suspected of having neoplastic disease by the referring physician. There is need for much greater awareness on the part of both laymen and physicians regarding the possibility of this disease in persons over the age of 40 who develop chest symptoms.
10. The authors believe that many patients with primary bronchogenic carcinoma are already beyond the curable stage by the time the initial symptoms appear. It is urged that efforts be directed toward discovery of the disease while it is still in a pre-clinical stage as a positive step in reducing the present high mortality rate by utilizing the tuberculosis case-finding machinery and by routine annual chest X-rays of all persons over 40.

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SOME OF THE LATE CLINICAL ASPECTS OF CAMPAIGN ACQUIRED TROPICAL DISEASES*

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THE QUESTION is occasionally asked today, "How often will doctors in civilian practice encounter the late stages of tropical diseases among service men who were exposed to these diseases in the tropics?" The answer to this question is "Not often," because most such diseases were recognized and treated during service by the medical branches of the armed forces. Yet just as recurrent vivax malaria is now occasionally met with among discharged service men, so may recurrent or late forms of other tropical infections come to the attention of civilian doctors. It is important that this possibility be kept in mind. The following brief case history will serve to illustrate the type of problem referred to.

H. K., a male, aged 21, was sent to a hospital for chronic care. He had been under observation for three months at another hospital with a stubborn illness and had there been carefully studied. His hospitalization was occasioned in the first instance by a furuncle on his leg. He had seen service in Italy and was sent to this country from there in 1944. He admitted that for a year or so he had been a bit breathless on exertion, and had noted a feeling of fullness and discomfort in his left upper abdomen. The features of his examination and study included marked pallor, an enlarged firm spleen extending below his umbilicus, a severe anemia with a red count just over 2 million, a well marked leukopenia, (white count of 2,000) and an extraordinary high plasma protein level, due to a plasma globulin of 6 grams per cent. The injection of adrenalin caused no appreciable change in his total white count. Extensive x-ray studies had not been revealing. The impression was that this patient suffered from some form of blood dyscrasia, such as aleukemic leukemia. He had been treated with this diagnosis as the most likely one, by transfusions and other measures, none of which had altered his clinical picture. The syndrome was clearly an unusual one. We were fortunate in having the opinion on this patient of Dr. Arthur A. Marlow, who had spent several years in China and who promptly recognized these features—anemia, leukopenia, high plasma globulin and enlarged spleen—as those found in the chronic form of kala-azar. A sternal bone marrow biopsy was done, and this showed unmistakable Leishman-Donovan bodies establishing the diagnosis as visceral Leishmaniasis, or kala-azar. Treatment for this condition was started, but unfortunately the complication of a ruptured colonic ulcer and peritonitis led to his death ten days after admission.

While this case was admittedly an unusual and even rare one, its parallels are not too unlikely. The purpose of this paper is to review briefly four forms of tropical disease that may be encountered among discharged service men who have been on duty in the tropics.

I

The first, most important, and most familiar to everyone, is amebiasis, or infection from endameba histolytica, which most commonly occurs in the form of amebic dysentery. It is clear that many instances of diarrhoea, some of them only transient, that occurred during either tropical or temperate zone service or in Japanese prisoner of war camps, were due to amebic infection. These infections were acquired through the ingestion of the parasite in its cystic form. Carriers without symptoms were probably the principal source of infection. Difficult sanitary conditions and the uncleanliness of native help, made acquisition of this disease in some quarters almost inevitable.

When recognized in its acute form, by the laboratory finding of either motile amebae or cysts (and there is no other way by which the diagnosis can be clearly proven) this disease can be successfully treated by modern methods. Some cases were not recognized in the service however, and others remained untreated for long periods. It is these, in whom the disease may have passed into a chronic form, with intermittent recurrences of diarrhoea due to amebic colitis, which all of us may see. There are three points about amebiasis of the colon that should be emphasized.

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(a) The severity of the disease is extremely variable. It may exist as a relatively mild infection with recurrent diarrhoea, crampy abdominal pain, with or without bloody stools. The stools are often bulky rather than watery. Amebiasis should always be entertained as a diagnostic possibility in any one, particularly an ex-service man, who presents this type of colonic disorder, whether mild or severe. Intermittent diarrhoea and abdominal pain are the points to remember.

(b) The diagnosis can only be established with certainty by finding either motile or otherwise recognizable ameba histolytica or cysts in a *fresh* specimen of stool. Routine stool specimens are notoriously unsatisfactory for this. The amebae rapidly disintegrate, and cysts may be few in number. If stools are examined, they should be examined on a warm microscopic stage within minutes and not hours after they have been passed. A useful technic to employ when the diagnosis is strongly suspected, and several stools have been negative, is to obtain on proctoscopic examination, with an ordinary serological pipette bent at a 45 degree angle and fitted with a suction bulb, a small amount of material from a rectal ulceration, or the base of a pin point hemorrhagic area which may overlie a superficial amebic abscess. Material obtained in this way may show many amebae when stool examinations have been repeatedly negative.

(c) In the third place, the diagnosis is of greatest importance because amebiasis is a serious disease and if not recognized and treated may produce disastrous results. The scope of this paper does not allow discussion of treatment in every detail, but the main points should be touched on. In the presence of symptoms, three drugs are essential:

1. Emetine hydrochloride. This should be given subcutaneously, 0.03 gms. (½ grain) twice a day for 6 to 8 days. Emetine is a toxic drug, should be given to patients only while they are confined to bed and should not be used in any patient with significant heart disease. Concurrently with the emetine the patient should receive
2. Carbarsone 0.25 gm. by mouth three times a day for seven days. This drug is contra-indicated in any patient with hepatic disease.
3. Carbarsone should then be followed by an organic iodine preparation, either diodoquin 0.6 gm. (10 grains) or chiniofon 1 gm. (15 grains) three times a day for seven days. It is important to emphasize that carbarsone and an iodine preparation should *not* be given at the same time.

In refractory cases, benefit may be obtained by retention enemas of 2 grams of carbarsone in 200 cc. of 2% sodium bicarbonate solution or 4 grams of chiniofon in 200 cc. of water. These should be given every night or every other night for five nights.

If the infection is present without symptoms or with very mild enteric symptoms, treatment by these mouth medications is called for without the use of emetine. The presence of liver abscess, another and a serious late manifestation calls for treatment with emetine and aspiration of the abscess with scrupulously careful technic. Open drainage should not be performed if it is at all possible to avoid it.

It should be emphasized that this program of treatment is advisable if the diagnosis is proven. In recurrent diarrhea where amebae or cysts are not found, it is better to treat the patient with other measures, including a course of sulfadiazine. There is risk in giving anti amebic drugs, especially emetine, just for a therapeutic trial.

II

Another disease that proved a serious hazard among our troops, in a much more localized zone of action, is that form of blood fluke disease known as 'Schistosomiasis Japonica'. This disease is endemic on the Islands of Leyte, Samar, Mindoro and Mindanao in the Philippines, and is acquired by the bite of parasites that live in fresh water. These parasites are dependent for their development on a certain type of snail, the snails having become infected from contamination of water by the feces of infected natives. The parasites are capable of penetrating the unbroken skin, so that any kind of contact with water from infested streams may lead to infection. This contact may be brief as from washing the hands or prolonged as from bridge building, bathing or wading, or working in rice paddies, as many of our prisoners had to do. Briefly, the parasite having found its way into the blood stream, matures in the intrahepatic portal system. In Schistosomiasis Japonica the adult parasite comes to inhabit, most commonly, the small tributaries of the mesenteric veins. Here the deposition of eggs by the female leads to minute abscess-like formations which in time rupture into the bowel. As a result eggs are passed in the feces, and their recognition there, again, is the only means whereby the diagnosis can be established with certainty. The acute stage of the disease which occurs within 5 to 6 weeks of the time of infection may vary markedly in the extent of symptoms it produces. Constitutional symptoms are common—fever, chills, headache, malaise, muscular aching, often abdominal discomfort or crampy pain, with which there may or may

not be diarrhoea. As in amebiasis, these symptoms are sometimes very transient, may clear up without treatment as a result of spontaneous remission, and the disease may pass unrecognized. In most instances among our troops however, medical aid was sought because of these symptoms and fever. An enlarged or tender liver and a leucocytosis with striking eosinophilia are the outstanding findings. Fortunately the majority of cases of acute Schistosomiasis occurred among troops in areas—such as Leyte—where the disease was known to be endemic, and where the medical corps was "on the alert", and recognized it in its early stages. Treatment for the disease consists of the parenteral administration of trivalent antimony compounds—either antimony and potassium tartrate or fuadin. Both are effectual, but both are toxic and must be given with caution.

It is not likely that we will encounter with any frequency the late stages of Schistosomiasis Japonica. Most of the cases, as noted, were recognized early and were treated at the time of onset. It is believed that the chemotherapy used by the armed forces instituted early will be effective in preventing the development of severe late sequelae. The untreated or recurring form of Schistosomiasis Japonica may go on over a period of several years to the development of intestinal proliferation and repair, resulting in thickening of the intestinal wall and papillomata formation. When this occurs in the rectum, the condition may be visualized by proctoscopic examination. Such a patient *may* have recurring abdominal symptoms with blood in the stools. As in amebic infection, careful examination of the stools, or of material from a rectal lesion, for the schistosoma eggs, should be made by an experienced laboratory technician. The eggs in such cases are harder to find than during the early stages. The eggs are about 80 microns in length, and are recognized by a spine on the lateral wall, near the end. In advanced cases, thrombosis of mesenteric vessels, and cirrhosis of the liver with ascites, anemia and leukopenia may occur. Such patients closely resemble the so-called Banti's syndrome. Metastatic lesions in other organs including the brain may develop and produce localizing symptoms and signs. The treatment for this condition calls for administration of a freshly prepared antimony and potassium tartrate solution given every other day in a course of 15 injections. This is the program adopted by the Army—both for early cases, and for treated cases that persist in showing eggs in the stools. It is important to point out that no ex-service man should be suspected of Schistosomiasis unless he spent time on Leyte, or other Philippine Islands, Japan or China. The disease is not transmitted from man to man unless the intermediate host—the snail—is present to infect waters, and fortunately that kind of a snail does not flourish in the United States.

III

A third condition that may possibly be encountered among ex-service men is visceral Leishmaniasis or kala-azar[2]. This is a generalized infectious disease involving the reticulo-endothelial system of the body. It is transmitted by the bite of the phlebotamus fly and there were many opportunities among our troops for exposure. People who have kala-azar in the acute form are usually acutely ill; the subacute or chronic form was not at all common among our troops. It should, however, be kept in mind. A case was recently reported[3] of a soldier returned from overseas who was at first thought to have subacute bacterial endocarditis. The clinical picture later looked more like aleukemic leukemia. One sternal marrow puncture was negative. On splenic puncture however, unmistakable Leishman-Donovan bodies were found. The patient was treated with a pentavalent antimony preparation, Neostibosan, and was cured.

Two points should be emphasized regarding kala-azar:

(a) The clinical features of the chronic form of the disease are emaciation, fever, enlarged spleen, anemia, leukopenia and a high blood globulin. These features may be present in many forms of severe blood dyscrasia. They should, suggest, however, the possibility of kala-azar in any soldier who has served in areas where the disease is endemic—namely in the Mediterranean area and the Middle East, in India, Burma and China. If kala-azar is suspected, sternal bone marrow or splenic puncture should certainly be performed to rule in or out this diagnosis.

(b) The second point is that adequate intravenous treatment for this disease with pentavalent antimony, in the form of the drug Neostibosan, has reduced the death rate from 80 or 90% to almost zero. The importance of making the diagnosis and instituting treatment is therefore obvious. Splenectomy is of no value, for the disease is a generalized infection, of which the enlarged spleen is only one manifestation.

IV

Finally a few words are in order about a disease which precipitated a great deal of fear and terror in many of our troops in some areas, largely because of its devastating effects among native population who have lived exposed to it for years. I refer to the disease filariasis, or Wuchereria bancrofti. One can imagine his own consternation if

continued on next page

he should meet up, face to face, with a group of South Sea Island citizens all presenting the disturbing features of elephantiasis and marked scrotal edema, particularly if one were told that their disease was transmitted to them by a mosquito and that the same kind of a mosquito bred and lived in that region. It is small wonder that it has taken weeks and months of reassurance to convince our troops that this kind of disfigurement and disability was not in store for them, particularly when they know that they were returned to this country as patients labelled "filariasis". It has created a problem which has been referred to as "filariasis hypochondriasis". Papers have appeared in the literature on the subject of psychosomatic aspects of filariasis[4]. The answer to the problem seems reasonably clear. A good many of our troops *did* become infected by this mosquito-born disease. They developed the characteristic symptoms and signs of early filariasis—fever, malaise, generalized lymphadenopathy, scrotal pain, tenderness and swelling, and attacks of lymphangitis. In a very few the micro-filariae were demonstrated in the blood; and in a few more the adult worms were found in biopsied lymph nodes. But all of them were returned to this country as soon as the diagnosis seemed reasonably certain and were treated in sizable groups in hospital centers. The experience at one of these centers was reported recently[5]. The course which these patients followed was generally one of progressive improvement interrupted at times with recurrent attacks of lymph node tenderness or lymphangitis. In none did chronic swelling remotely approaching elephantiasis occur. Many of them still had palpable lymph nodes; some would occasionally develop recurrent lymphangitis which was treated symptomatically and lasted only a few days. But very commonly they were seriously concerned about their future and were sure they were "in" for further trouble. The experience generally has been that this is an ungrounded fear, and that reassurance opposing it is entirely justified. The serious late sequelae of filariasis are rarely seen in natives under the age of 20—a fact which means that long exposure and repeated re-infection is necessary to bring about the stage of elephantiasis. The fact that our troops were sent home as soon as early minimal infection seemed either evident or even likely, bespeaks very little possibility of future complications. And so if any of us see a veteran known or thought to have acquired early filariasis in Samoa, the Fijis, Wallis Islands or South China, we should calm his fears, treat him symptomatically and approach his problem from the standpoint of sympathetic encouragement and reassurance. There is no specific treatment indicated.

In closing, two points should be mentioned.

(a) The first is that while complement fixation tests or skin tests have been utilized in the study of all of these diseases, none of them is highly specific, the anigens are not easily obtained and there is little gain in waiting for them or depending on them to help make a diagnosis. If the diagnosis is suspected it should be confirmed by trying to find the parasite itself, be it in the form of ameba, cyst, or ovum.

(b) The other is that while on the one hand we should be mindful of these possibilities in appropriate instances, we should on the other hand run down carefully all epidemiological clues, and not be guilty of suspecting, for instance, schistosomiasis in a patient who spent his entire time on duty in this country and was never exposed to the dangers of Leyte or some other tropical island.

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NEW FELLOWS OF THE RHODE ISLAND MEDICAL SOCIETY

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THE TREATMENT OF HYPERTENSION WITH RICE DIET*

FRITZ BEHRENDT, M.D. *and* ALEX M. BURGESS, M.D.

The Authors. *Fritz Behrendt, M.D. of Howard, R. I., Psychiatrist, Rhode Island State Hospital for Mental Diseases. Alex M. Burgess, M.D., of Providence, Chief of Medical Service, Rhode Island Hospital.*

THE recent reports of Walter Kempner[1, 2] on the treatment of kidney disease and hypertensive vascular disease with rice diet suggest the desirability of additional studies of the effect of rice diet on patients who have been known as hypertensive for many years. The State Hospital for Mental Diseases has appeared to us to be an unusually suitable location for such a study. Because of the recording of blood pressures on annual physical examination it was possible to select a group of hypertensive patients who had been under observation for many years. The effect of rice diet could be studied without materially altering the mode of living as would occur if patients ordinarily living in the community were hospitalized for such a study.

Seventeen women patients were selected who had been in residence in the State Hospital from 8 to 36 years. The average duration of residence was 24 years. The records of all patients selected showed diastolic blood pressure readings of 110 mm. or over. Such readings had been recorded over a period of one to sixteen years with an average duration of seven years.

These seventeen patients were placed in a ward for their exclusive use. All were kept on regular ward diet between August 15 and September 25, 1944. This initial period of six weeks was devoted to establishing the usual range of blood pressure readings in each patient on regular diet and to performing physical and laboratory examinations. The following procedures were carried out: physical examination; eyeground examination by Dr. Harry Messinger, electrocardiographic studies; blood urea nitrogen and blood sugar determinations; urinalysis and urine concentration tests. Temperature and pulse were recorded twice daily on the clinical chart. Weights were recorded weekly.

Laboratory findings revealed no evidence of impaired kidney function except in two patients. These two patients will be discussed in greater detail later.

The retinal arteries were described by Dr. Messinger as "narrow and pale" in the majority of patients. Hemorrhages and exudates were seen only in the fundi of one.

Effect of Rice Diet

On September 25 alternate patients (nine) were placed on rice diet as described by Dr. Kempner. The following outline details the diet.

RICE: Any kind. Brown, polished, wild, etc. Boiled or steamed without salt, milk or fat of any kind (no butter, margarine, drippings, lard, grease, salad oil, etc.)

FRUIT: All kinds, preferably fresh (raw or stewed) but also dried, frozen, canned, or preserved. (No salt added). No nuts, dates or avocadoes.

SUGAR: White or brown, also honey. No syrups. (No Karo, etc.)

FRUIT JUICES: All kinds, fresh or canned. (No vegetable juices, no tomato juice).

FLUIDS: (Only fruit juices) limited to about 1½ to 2 pints daily.

ADDITIONAL MEDICATION PER DAY:

Vitamin A	5000 units
Vitamin D	1000 units
Thiamine chloride	5 mg.
Riboflavin	5 mg.
Niacinamide	25 mg.
Calcium pantothenate	2 mg.
Ferrous sulfate	0.6 gm.

The composite Chart I shows that within about a week of the introduction of the diet, the average blood pressures fell from a range of 170-190 systolic and 84-96 diastolic to about 150 systolic and 90 diastolic. Furthermore, this fall in blood pressure was maintained as long as the patients were on the diet. There was considerable variation in the degree to which the blood pressures of individ-

continued on next page

* Presented before the Providence Medical Association at Providence on December 2, 1946.

[1] Kempner, W.: (a) Treatment of Kidney Disease and Hypertensive Vascular Disease with Rice Diet, North Carolina M. J. 5:125-133 (April); (b) 273-274 (July) 1944.

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Weekly Averages of Blood Pressure Readings

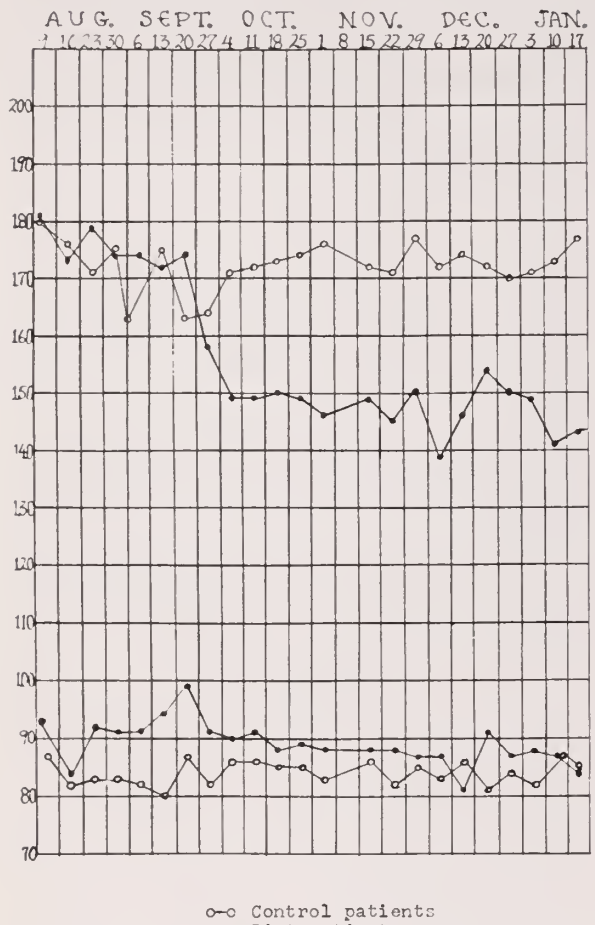


CHART 1

ual patients showed a response. In general, patients with the higher pressures showed greater responses though one patient with a very moderate hypertension showed a drop to within normal range. Only two patients failed to show a clear cut response.

During this same period of time, October 1 to February 1, none of the eight patients on ward diet showed a fall in blood pressure readings.

Eyeground examinations on August 23 (before diet) and March 29 (patients still on diet) showed no changes except in the control case EG (to be discussed below).

Electrocardiograms before diet and toward the end of the diet period showed no essential change.

Two patients showed definite evidence of impaired kidney function.

TS a fifty-two year old woman was first studied for hypertension at the Rhode Island Hospital in December 1930, at the age of thirty-nine years. The history stated that she had had occipital headaches and vomiting since the age of nine years and that she was said to have had hypertension at that time. Her mother and sister had high blood pressure. Her mother died of cerebral hemorrhage at the age of forty-five years.

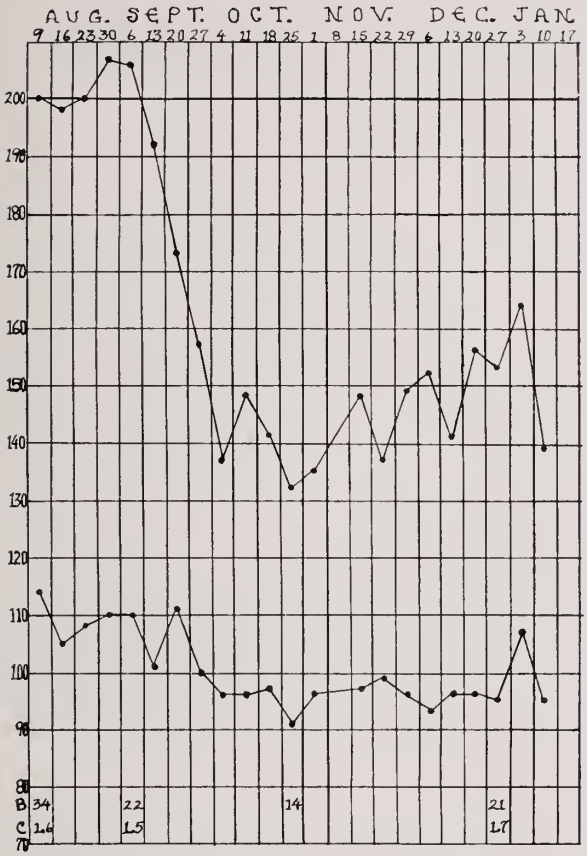
In December, 1930, and January, 1931 fourteen blood pressure readings are recorded ranging from 230/130 on admission to 114/70 with, in general, lower readings after bed rest.

In January, 1931, one of us, Dr. Burgess, elicited a fall in blood pressure from 190/120 to 160/78 with amyl nitrate. Patient was again admitted to Rhode Island Hospital in June. 1931, because she had collapsed on the street on three occasions, and had suffered from headaches, dizziness and shortness of breath. Examination showed blood pressure readings from 230/130 to 180/110, slight oedema of the lower extremities, moderate cardiac enlargement to the left and downward, and a slight blowing systolic murmur at the apex and aortic area. Electrocardiogram showed beginning myocardial impairment. On her third admission in May. 1933, blood pressure readings were recorded as 200/120 and 220/120. Electrocardiogram showed evidence of further myocardial damage and X-ray showed considerable enlargement of the heart shadow with tortuosity of the aorta and prominence of the aortic knob. Urinalyses showed rare casts, rare W.B.C., rare R.B.C., and Specific Gravity 1.006-1.019. On her fourth admission in June, 1934, patient showed swelling of the ankles and abdomen, and a blood pressure range of 230/120 to 200/100. There were no noteworthy changes in the physical or electrocardiographic findings. At this time she slept with two pillows at night, showed palpitation on exertion and considerable dyspnea. She gave a history of occasional attacks of precordial pain brought on by exertion. The pain was sharp and ran through to the back. From August 6, 1934, until April 25, 1944, she resided in the State Infirmary. There the leading change in her condition was a progressive mental deterioration which was considered due to hypertensive encephalopathy. She became so unmanageable and abusive to other patients that she was transferred to the State Hospital for Mental Diseases.

The range of blood pressure readings during the initial period of study and the dramatic fall when she was on rice diet is indicated in Chart 2. It will be noted that there was a drop of about 60 mm. in systolic pressures and 15 mm. in diastolic pressures, and also a decrease in blood urea nitrogen values.

EG is a sixty-seven year old woman whose blood pressure was first recorded in this hospital in 1928.

Weekly Averages of Blood Pressure Readings
PATIENT TS



B = Blood Urea Nitrogen in mg. per 100 cc.
C = Blood Creatinine in mg. per 100 cc.
Rice diet began during week of September 20.

CHART 2

At that time (age 50) blood pressure was 180/100 and hyaline casts were noted in her urine. There were readings recorded in 1930 of 195/110 and in 1933 of 210/128. In 1943, rare, fine granular casts were noted in the urine; blood urea nitrogen content was 37.5 mg. and blood pressure 230/120.

Throughout the period of the study patient was kept on a regular ward diet. Her blood pressure readings varied from 190 to 240 systolic and 98 to 120 diastolic. Blood pressure readings remained at a relatively constant level from August, 1944, to March, 1945, with a blood urea nitrogen value of 35 to 60 mg. She was placed on rice diet in April 1945. Blood pressure readings fell to 170/90-180/100, and blood urea nitrogen content dropped to 10-12 mg. She was returned to a house diet for about two weeks in August, 1945, with a return of blood pressure to 200/104 and blood urea nitrogen to 70.

Discussion

Kempner states, (2) "since, according to our hypothesis the rice diet acts by compensating renal metabolic dysfunction one may assume that in those cases in which blood pressure decreased under treatment the hypertension was not 'essential' but was due to some impairment of the metabolic function of the kidney". He adds that rice diet can be considered a therapeutic test to differentiate cases of essential hypertension from those due to renal dysfunction. In view of the fact that eight out of nine of our patients showed no evidence of renal damage and yet six of these eight showed definite response to rice diet we are inclined to differ with Kempner. We feel that the rice diet does not differentiate between hypertension on the basis of renal dysfunction and "essential" hypertension as both conditions may be modified by rice diet.

In Summary

1. Seven of nine patients showed a substantial drop of blood pressure about one week after being placed on a rice diet as described by Kempner.

2. Two patients who showed an elevated blood urea nitrogen when on house diet, showed normal values when on rice diet.

3. A decrease in hypertension occurred in patients both with and without evidence of kidney disease.

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INFLUENZA VACCINATION

INFLUENZA vaccination occupies a prominent position before both the medical profession and the public at this time. As is usual in writings addressed to the larger group the stand is unequivocal. The public's world is black and white. They have little use or admiration for the gray tints which the scientist so sorrowfully finds makes his accurate perception difficult.

Thus a popular article tells the public that there will be no large scale epidemic of flu this time; it can be scotched with a new vaccine which assures control.

Large groups of industrial workers, hospital employees, and others are now receiving mass treatments with the vaccine. Nevertheless, we hear of physicians of standing who apparently still have doubts and indecisions, and are not routinely giving all their patients this panacea at present. That an over-all picture of the medical attitude might be had we have asked two able internists to give the two viewpoints pro and con and we are printing them below:

Pro

Wide variations exist in the clinical picture of influenza virus infections. An Army immunologic investigation of upper respiratory tract infections in 1943 revealed that 40 per cent had been due to influenza virus A or B. In addition to being the cause of a relatively mild disease, albeit one that costs the loss of much time, influenza virus is sometimes associated with a severe disease like the epidemic of 1918.

The Commission on Acute Respiratory Diseases, after studying epidemics of influenza between 1920 and 1944, has pointed out that influenza A has a periodicity of two or three years while influenza B has a periodicity of four or six years. Based on this information an epidemic of influenza A was predicted for the winter of 1945-46. This did not occur, making the possibility of its appearance in the winter of 1946-47 even greater.

The vaccine now produced is a mixture of Influenza A and B virus cultured and harvested from chick embryo. This vaccine has been shown to raise the titer of antibodies against these viruses to a high level. This level is maintained for four to five months and then falls to about 50 per cent of its highest level at the end of ten to twelve months.

The army has made extensive study of the value of this vaccine. Among many thousands of soldiers vaccinated, only 2.2 per cent were admitted to army hospitals with "typical" influenza while 7.1 per cent of the unvaccinated were so admitted—a 75 per cent reduction in attack rate.

The vaccine does contain some chick protein and the danger to those individuals who are sensitive to

such proteins is obvious. It has also been pointed out that the possibility does exist of sensatizing individuals to such proteins and so making subsequent injections dangerous. In the December 12 issue of the Journal of the American Medical Association there is a report of the use of the vaccine in 108 known allergic children. Only 5 per cent were found to be sensative enough to warrant cautions in the administration of the vaccine—that is, by desensatization. The Surgeon General's Office has reported that serious reactions have been reported but the number of reactions known to have occurred are negligible in comparison with the number of doses administered—now in the millions. However, the physician should be alert to pick up a history of allergy—asthma, hay fever, eczema, intolerance to eggs, or the past administration of vaccine against influenza virus, typhus fever, or yellow fever—and either reject these individuals or do a preliminary skin test with the vaccine.

Possibly the greatest field of usefulness of this vaccine will be among large groups such as industrial plants, hospitals and schools where the loss of time occasioned by epidemics of upper respiratory infections causes the slowing down or even the complete breakdown of a closely integrated program.

Con

During recent months the subject of vaccination against influenza has been very widely discussed. As has been true with other therapeutic measures of wide popular appeal—such as the wholesale use of vitamins—there has been more clamor for its use by those outside the medical profession than by the doctors. It is, therefore, useful to examine the basic scientific facts involved before deciding on its value in the prophylactic treatment of large numbers of people.

The commercial vaccine now available is essentially the same that was developed and studied by the Army Commission on Influenza in 1943-44. It consists of a mixture of influenza A and B Virus, grown on egg yolk, and inactivated with formalin. Injection of 1 cc of this vaccine has been demonstrated to produce a variable degree of protection in large groups of individuals as compared with unvaccinated controls. The ratio of cases of influenza in the vaccinated and unvaccinated groups was found to be about 1 to 5.

There are, however, drawbacks to the general use of the vaccine. The duration of immunity is not known, but available evidence indicates that it may be quite brief, i.e., only a few months. Reactions, both local and constitutional, are fairly frequent, and as this vaccine contains egg protein, severe allergic reactions are occasionally encountered. This has prompted most workers in the field to refrain from giving the vaccine to individuals with any history of allergy. Finally it is often forgotten, especially by laymen, that even if effective, this vaccination provides no protection against the great majority of winter respiratory infections —the "colds" and "grippe" that are always with us. Even an epidemic of influenza, if and when it does come, may well not be due to either A or B virus and hence not influenced by the immunization.

The army itself, after vastly more experience with mass vaccination than any other agency, has apparently decided against its routine use, for the last published directives state that it is to be withheld and given only when directed in the presence of an epidemic. Conditions in camps with large bodies of men in close contact offer ideal conditions for the spread of such epidemics. Certainly in civilian practice and from the point of view of the individual patient there is much less reason for the use of the vaccine. In a review of the whole subject, published in the New England Medical Journal, 5 September '46, Edsall states that "at present there is no apparent justification for widespread or routine use of the vaccine, in the absence of a clearly defined epidemic of Influenza A or B."

INFANTILE PARALYSIS IN 1946

The report of the National Foundation for Infantile Paralysis for 1946 has recently been received. Receipts amounting to nearly sixteen and one-half million dollars are reported, one-half of which is retained in the treasuries of local chapters for office expenditures and medical and nursing care. Appropriations totaling seven and one-half million to virus research, six hundred thousand dollars for after-effects research, three million dollars to education and two and one-half million dollars for medical care. The expenditure of such a large sum of money implies corresponding responsibilities. Infantile paralysis is responsible for 22 per cent of all deformities. No disease creates greater apprehension than infantile paralysis because it may produce such tangible and lasting crippling in the victim. The March of Dimes campaigns, held annually at the birthday of the late President Franklin D. Roosevelt, has stirred the emotions of the public to a high pitch, especially in view of his own dramatic involvement as a patient. The recent prominence given to the Kenny treatment has served further to focus attention on this dreaded disease and to stimulate research with a view to its eventual eradication. It is open to question, however, if too much importance is not being devoted to the problem of infantile paralysis, in view of the greater crippling produced by heart disease, cancer and arthritis among the public at

continued on next page

large. Governor Pastore sounded a timely warning on this point at the annual dinner of the Rhode Island Medical Society last spring.

The conviction of the public that they can handle medical matters be ter than medical men; a point of view which they do not hold towards engineering or legal problems for instance, is no where more evident than when poliomyelitis is concerned. The New England Journal of Medicine has just issued a well merited rebuke to a Boston columnist. In his omniscience, the product of several years at college and some more on Boston newspapers, he has chosen to criticize, in the far from judicious manner of his ilk, the methods of the state and local health authorities in handling an epidemic. This is in keeping with Hollywood's voluntary solution of one of the most difficult of orthopedic problems.

In order to clarify the situation in regard to our present knowledge of this disease, the American Orthopedic Association has authorized the publication of a Primer of Infantile Paralysis and preliminary proofs of the publication have been received. It is a concise and authoritative digest of our present knowledge of anterior poliomyelitis with especial reference to the more recent studies in etiology and in methods of treatment. As has long been recognized by orthopedic surgeons, nothing new in the way of therapy has been added by the adoption of the Kenny treatment. The old principles still prevail, but by the use of the Kenny methods, treatment has become more laborious and expensive without improving the end result. As one orthopedic surgeon has expressed it, "What is good is not new and what is new is not good."

No panacea has as yet been discovered to combat this disease at its onset, although it is probable that continued research will ultimately solve the problem. In the meantime the medical profession and the public at large may rest assured that no stone is being left unturned in the fight to conquer this affliction, particularly as it involves children. Cooperation between the medical specialties, nursing and sociologi al workers has been excellent. Stimulated by research and ample facilities for treatment in the larger medical centers, the care of these patients may be carried out with confidence even in remote areas.

LIFE WITHOUT MEDICINE

We have received the tenth anniversary number of Life, a beautiful and interesting magazine. With wonderful photography and clever concise writing it tells of the events and changes of these incredible ten years. The war is depicted, great industrial developments, social changes, the ravishing girls of the movies, the Rubens-like fat and naked ladies that our artists paint, the birth of a baby that was shown in the first number of this periodical and, again in the art portion, at least two episodes nine months premature to such an event.

What we searched for, however, was some reference to medicine's part. And this we found only in the advertisements. Advertising, like politics, makes strange bedfellows. To our mind the advertising of our great drug houses is of the highest quality, in marked contrast to the meaningless bombast so generally directed against one's sales resistance.

Thus Parke Davis has a page about pneumonia which is of genuine educational value. Here it is pointed out that many pneumonias can be successfully combated by the sulfa drugs and penicillin. In still another type streptomycin promises to be of value. They state that less than half as many Americans die now from pneumonia as in 1934.

The use of sulfa drugs to combat infection has developed almost entirely in the last ten years. Penicillin was freed for general medical use only three years ago and streptomycin is just beginning to be used. It is safe to say that the general lowering of mortality cited for pneumonia is due almost entirely to this newly-developed chemotherapy. The use of these agents is producing correspondingly gratifying results in meningitis and a host of surgical infestions as the venereal diseases.

Although blood transfusions as a practical matter date back at least a generation, the founding of blood banks and the everyday use of enormous quantities of whole blood, plasma and serum is a development of the past decade. And now the fractionization of blood is giving us products of great value in controlling hemorrhage, the communicable diseases, etc.

There are the more striking medical developments of a short era in which our profession made stupendous strides. Our delinquencies have been recited by strident voices from the President through Senator Wagner down to every organ of opinion in the country. It seems singularly obtuse that a consideration of the past ten years should give not a thought to our startling achievements.

"BE IT RESOLVED, ... "

This is the season of year when the youth of America, at the high school level, gird themselves for the battles of the debating platform. Embryo researchers are delving into the files to accumulate information, factual and otherwise, to clothe the arguments by which they hope to win forensic victories over their colleagues.

Medicine has a particular interest in the national high school debate topic this year for it is on the resolution that the federal government should pro-

vide a system of complete medical care to all citizens at public expense. Congressional leaders, state and municipal authorities, industrial and labor organizations, co-operative groups, as well as men of medicine, have discussed and debated the question of voluntary versus compulsory national medical care at great length the past few years.

That the high school students are now exploring the question is most commendable from an educational point of view. But, mindful of Macaulay's saying that half-knowledge is worse than ignorance, we fear for the factual presentations of some of the debaters if they rely on reports we have read in recent months. Particularly do we have in mind the presentations on the Wagner-Murray-Dingell proposal, and the misuse of selective service statistics.

Unfortunately too much of the popular reading has stressed federal dependency, and there have not been enough presentations to offset clearly this trend in thinking. The action, therefore, of the Association of American Physicians and Surgeons to start a national essay contest on the American system of the private practice of medicine comes at an opportune time. The plan proposed calls for an essay of 1,500 words or less by a high school student on the subject "Why The American System of the Private Practice of Medicine Gives the Finest Medical Care the World has ever Known," with each county medical society furnishing cash prizes for local competition, the state medical society offering prizes for the three top winners, and the AAPS three prizes for the best essays resulting from the nationwide competition.

The program will undoubtedly win favor. It is a step from the passive to the progressive stage in presenting opportunities to explore the American system of voluntary medical care.

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SCIENTIFIC ASSEMBLY OF THE RHODE ISLAND MEDICAL SOCIETY

(Joint meeting with the Providence Medical Association)

AT THE MEDICAL LIBRARY . . . MONDAY, FEBRUARY 3, 1947, at 8:30 P. M.

Check the date Now!

CLINICOPATHOLOGICAL CONFERENCES

Rhode Island Hospital

Name: K. C.

Age: 55

Physical Examination:

Pulse 80, respirations 20, blood pressure 140/70. No lymphadenopathy. *Thorax* was symmetrical, equal expansion but limited. *Heart:* Left border at the anterior axillary line, systolic-apical and aortic murmur. *Lungs* showed dullness and decreased breath sounds with rales on the left side. Right side was hyperresonant. There was weakness of the right hand.

Laboratory:

The x-ray taken on admission showed a diffuse, mottled infiltration throughout both lungs and was reported as suggestive of miliary tuberculosis with elevation of the right diaphragm and moderate atelectasis of the right lung and lateral scoliosis. Repeated two days later it was reported as indicative of extensive infiltrative pathology on both sides, more on the right, with moderate atelectasis of the right upper lobe. The entire base was reported as being suspicious of possible malignant neoplasm with extention from the mediastinum to the right upper lobe, secondary atelectasis and secondary lymphatic spreading in both lungs. The possibility of submaxillary tuberculosis with partial atelectasis of the right upper lung was also suggested. A lateral x-ray taken December 24th showed the usual shadow of interlobar fluid on the right.

From admission to this time palliative procedures were employed. The general impression was that the patient had carcinomatosis of some undisclosed primary site with generalized metastasis to the lungs.

A bronchoscopy was performed on January 16. Direct visualization showed, 2½ cm. from the carina on the right side, an apparent bulging of the mucosa into the bronchi obstructing it and just above this was a spur, horizontally located, about five times its normal thickness. Thin, frothy-like material was coming from the opening of the bronchus in this area. A specimen of the bulge on the floor of the bronchus was removed which, on study, was diagnosed as chronic bronchitis. The day following bronchoscopy she developed the aforementioned high temperature; the diagnosis of pneumonia of the right lung was made. She was treated with sulfadiazine with apparent good clinical effect within eight days. On January 18 a right thoracentesis was performed; a small amount of serous, semi-purulent material was removed which on examination showed a yellowish fluid containing a pelicle which was centrifugal. Microscopic description revealed fibrin, red blood cells and white blood cells, primarily polymorphs. There were small groups of large cells with a copious amount of cytoplasm showing no mitotic figures. There appeared to be mesothelial cells. No evidence of tuberculosis was seen. There were numerous, large empty vacuoles which presumably represented lipoid material. They were surrounded by large mononuclear phygocytic cells with foamy cytoplasm. The laboratory felt they were difficult to explain unless the patient had had some injection of fatty material such as lipiodol.

A thoracentesis was again performed on January 31. Her temperature, at this time, which was the 43rd hospital day, had again risen to 105 and she expired twelve hours later.

Other laboratory studies were: *Hematology: 12-19-44:* R.B.C. 4,030,000; W.B.C. 7,750, P.76, L.23, M.1. Hemoglobin 12.7. *1-11-45* R.B.C. 4,130,000; W.B.C. 9,300, P.79, L.17, M.3. *1-23-45:* W.B.C. 15,150. *1-25-45:* W.B.C. 18,500. *1-29-45:* W.B.C. 19,250, with 96% polys, 3% lymphs. *1-31-45:* W.B.C. 7,800.

Urinalyses: 1-19-45: Sp. Gr. 1.018; Protein 1, rare red blood cells. *1-20-45 and 1-21-45:* Essentially the same findings. *1-23-45:* Essentially the same except there were many sulfa crystals. *1-26-45:* Essentially as on admission.

Chemistry: 12-19-44: BUN 24; Glucose, 74, Total protein 5.7. *12-27-44:* BUN 22. *1-23-45:* BUN 21.

Sputa and urine were examined for acid fast organisms frequently and were always found negative. Fluid obtained from the pleural cavity negative for acid fast organisms but hemolytic streptococcus was grown out of the first fluid. A guinea pig was inoculated from the fluid obtained from the pleural cavity and it was killed two months later and found negative for acid fast. A guinea pig was inoculated from a urine specimen and killed

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

CLINICOPATHOLOGICAL CONFERENCES

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within two months and found negative for acid fast.

Electrocardiogram taken December 20 was essentially normal.

COURSE

Temperature varied between normal and 99.5 until the day before bronchoscopy, that is the 29th hospital day, at which time it rose steadily within thirty-six hours to 104.5 and subsided by lysis during the next ten days to the usual 99.5. This continued for two days after which there was a steady rise to 105 at which time respirations ceased.

* * * * *

Dr. Harrington: I will put these chest x-rays up so that we will all have an idea as to what was going on in the chest of this patient. This is an extremely unusual and complicating case, in which a 55 year old female patient was so ill when she was admitted to the hospital that medical treatment offered little in the way of help and surgical intervention, if such was deemed necessary, would seem to be too great a risk. She posed a problem that was difficult to solve while the patient was alive.

The patient was in good health until six months ago, at which time she noticed the onset of loss of strength, weight and appetite, plus a productive cough. Four weeks prior to admission, her symptoms increased, when she developed a new cold which she could not get rid of.

On admission, she complained of being extremely weak, dyspnoeic, had severe night sweats, productive cough without hemoptysis, but with foamy expectoration, and chest pains with the coughing. The day of admission, she noticed, for the first time, weakness of her right hand with inability to oppose the fingers or to hold objects tightly. It may have been this that caused her to come to the hospital.

When she was admitted physical examination showed the patient to have weakness in the right hand. The other positive findings were limited expansion of the chest, plus copious and extensive rales, some dullness. Her heart apparently was displaced to the left anterior axillary line. There appeared to be systolic-apical and aortic murmurs. The abdomen was negative. The extremities were otherwise negative. Blood pressure was essentially normal, 140/80.

From the physical examination alone, we might expect the patient to have had in one respect a cerebral disorder, producing neurological manifestations in the hand. However, the major pathology must necessarily be in the thoracic area. The only help that could be obtained to further the diagnosis in that regard would be from the x-ray. This diagnosis of extensive chest pathology was supported by the original x-ray which showed a few mottlings throughout the left lung, extensive mottling throughout the right lung, plus a rather definite, somewhat concentric area of increased density in the right hilus and another such area behind the sterno-clavicular junction on the right. To this was added an elevation of the right diaphragm, more than we would expect to find normally.

Regardless of whether the right hand entered the picture or not, the major pathology that we have to deal with in diagnosis is in the chest.

The blood studies were not of any help. As you can see, she had a red count of over 4 million, and over 70 per cent hemoglobin, and the white count was essentially normal, with the normal distribution of the cells. There would be no point in trying to tie a diagnosis into the findings of the blood stream.

The urinary findings were essentially normal. There was a one-plus protein in the urine, but in a chronic disorder of this nature and so extensive, we might say: "What of it?" It did not affect her immediately.

The blood chemistry was BUN 24; Glucose 74, Total protein 5.7 on December 19, 1944. On December 27, 1944, it was BUN 22. On January 23, 1945, the BUN was 21. The blood protein might have entered into the differential diagnosis, but the blood sugar does not; therefore, the laboratory offered no positive help in the diagnosis.

The physical examination merely located the site to investigate more thoroughly.

The x-ray does point out the extensiveness of the disease, and offers two possible diagnoses:

1. Miliary tuberculosis.
2. Carcinomatosis, probably metastatic.

Both of these, naturally, have to be stressed, because nothing else could be thought reasonable so early in the patient's hospital stay.

In an effort to prove tuberculosis, the urine was studied frequently, by direct smear, with guinea pig inoculations and by culture, and if tuberculosis were present, it didn't involve the kidneys. The sputum was also examined for acid-fast organism. That, too, was found negative. So if the patient had tuberculosis, she didn't have it in such a way that any secretions or exudate from the body would aid in the diagnosis.

I think that we can say she didn't have pulmonary tuberculosis. If she had pulmonary tuberculosis, so extensive, I feel that there would also be sufficient destruction to produce bacilli.

I would like to move on, now to the carcinomata. There was no primary evidence of carninoma. Pelvic examination was done, and although un-

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NO. 7 in Schenley Laboratories' continuing summary of penicillin therapy.

EMPYEMA:
treatment with PENICILLIN SCHENLEY

Penicillin exhibits a marked ability to sterilize pleural effusions whenever the infecting organisms are penicillin-sensitive. It is most effective when administered in large doses during the incipient stages. Patients should be observed carefully for at least two weeks after discontinuance of penicillin therapy to avoid possible recurrence.[1]

In the management of empyema, it is especially appropriate to apply the maxim:

1. Poppe, J. K.: J.A.M.A. 129: 435 (Oct. 6) 1945.



PENICILLIN SCHENLEY. Treatment: Penicillin solution is injected directly into the pleural cavity after aspiration and after irrigation with sterile isotonic salt solution, if necessary. Penicillin should not be used for irrigation. The optimum dose for each injection is 50,000 to 200,000 units in a volume of solution less than the amount of fluid or pus aspirated. The frequency of injections depends on the extent, type, and severity of the infection, and the response to therapy. Treatment should be continued until after the fluid becomes sterile.



Surgical intervention is necessary if fibrin masses or loculation prevent adequate aspiration or if penicillin therapy is ineffective, as indicated by persistence of positive cultures after one week.



SYSTEMIC THERAPY. Systemic use of penicillin is indicated as a supplement to intrapleural therapy particularly where there exists an underlying active pulmonary infection or a bronchopleural fistula.

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Russell, H.G.B., abstracted, Proc. Roy. Soc. Med. 36.401.



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CLINICOPATHOLOGICAL CONFERENCES

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satisfactory, it was not so unsatisfactory that it bore repetition. It was not repeated. It was felt that there was no pelvic pathology. The patient at no time had abdominal symptoms. There was no reason to go into the abdomen. As far as the localized thoracic carcinoma or localized malignancy is concerned, that does have to be considered. In an effort to find a bronchogenic lesion, a bronchoscopy was performed, which showed a bulging of the right, main bronchus, and this bulging was interpreted by the bronchoscopist as a pressure from without. A biopsy of the mucosa from that area was reported as a chronic bronchitis.

That still left us not being able to make a diagnosis of carcinoma. Furthermore, with such a relatively good red blood cell picture, and hemoglobin, I think we would almost steer away from that temporarily, (4 million RBC and over 70 per cent, hemoglobin).

During this time, there was a neurological consulation and the opinion of the examiner was that the patient had a cerebral accident, or as he described it a right hemiplegia. I don't believe he offered a possible diagnosis as to why the hemiplegia was present.

In the course of the disease, patient developed a right pleural effusion. This fluid was aspirated and examined in the laboratory and reported as having some fat cells in it. It was thought by the laboratory that it could be explained by lipiodol. Since lipiodol was not used, we must assume it to be a chylothorax.

I think that now we must go definitely into the differential diagnosis of a condition which can produce such an extensive bilateral pulmonary mottling, large concentric shadows in the right hilus area, and a chylothorax.

My own feeling is that the essential pathology is not in the lungs either. The essential pathology appears to be in the mediastinum. In order to arrive at the diagnosis, we have to consider anything that could produce pressure on the bronchi and pressure on mediastinal lymphatics.

We will rather quickly rule out the cardiovascular system. Certainly, there is no reason to suspect that this patient had a pulmonary oedema, and it in no way falls in line with it. There was no evidence of cardiac enlargement. The aortic murmur and the systolic murmur could easily be explained. Any one of this age, 55 years, regardless of the etiology, might have such murmurs. However, aneurysm can produce pressure on lymph glands and cause obstruction of the drainage of the glands and cause obstruction and pressure on the bronchi and produce atelectasis and chylothorax, in other words, the picture we find here. However, if it was

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aneurysm it couldn't be of the ascending portion of the aorta, because if it were, there would be exterior signs of the aneurysm, e.g., bulging through the anterior chest wall. Certainly there might be an aneurysm of the posterior portion of the aortic arch. Although we cannot rule it out, yet we have no supporting evidence of it. Furthermore, saccular aneurysm doesn't occur, or rather it is extremely rare in the female. With the lack of supporting laboratory evidence that could easily be determined, I could not entertain this diagnosis too long a period of time.

We have to consider solid tumors; neurofibromas, and sacromas. Even carcinoma has to be considered. Solid tumors, when occurring in the mediastinum, seem to produce more venous dilatation than this patient had. There was no report of such on her physical examination at any time, nor was there mention of venous distention about the neck and upper chest. Furthermore, solid tumors in the mediastinum are more apt to produce pressure necrosis, and pain along the intercostal nerve, resulting in severe pain low down in the chest and abdomen.

Discarding the solid tumors as causing the pulmonary picture, we are left with possibly a bony disease as the cause. We could think of a possible Pott's disease with the destruction of the bodies of the vertebra, with resultant abscess. Although there was some evidence of scoliosis, it wasn't great. In Pott's disease, of course, there is frequently an extension of the process intramuscularly. We frequently get the abscesses on the anterior chest wall. In Pott's disease, there is a burrowing, rather than extensive spread, such as this patient had. We are all familiar with the pathology which Pott's disease in the lumbar vertebrae causes. I would automatically discard this diagnosis rather soon.

It seems to me that this must be a soft tumor. It is not a solid tumor. It is not an expansile tumor. It must therefore be a soft tumor, and that soft tumor, I feel, is in the mediastinum, involving several of the glands, and besides that, it is also obstructing the flow of the thoracic lymph channels. This could be a hilus tuberculosis, or Beck's sarcoid. However, in Beck's sarcoid during the recent years, we have come to expect elevated protein, and elevated blood calcium, plus rarefaction in bone, none of which are here to support the diagnosis. We have no supporting diagnostic evidence so we may eliminate this entirely.

However, hilus tuberculosis is not uncommon. It was infrequent in the literature until 1914. During the first World War, it seemed as though it obtained much more prominence and was very much in the literature following that. It is a condition in which the primary focus present in the mediastinum glands, sometimes, in later life breaks down. It breaks down with a spread of the disease in any and all directions.

In this particular case, I feel that the spread was peripheral; it is not bronchial. I think that the shadows here in the hilus are tuberculous glands; they caused obstruction in the right upper lobe of the bronchus, with partial atelectasis, with resultant elevation of the diaphragm. I think, too, that the obstruction affected the thoracic duct, with a partial or early chylo-thorax. I can in no other way explain fat in the fluid from the right thorax. Certainly, the patient did not have lipiodol. Patient must have had a chylo-thorax on the right.

I am not completely leaving out the neurological picture. I explain the hand paralysis as a brachial neuritis. It is not unusual when any tumor or gland causes pressure in the brachial plexus to observe a wasting of the hand affected.

Dr. Clarke: Is there any discussion of Dr. Harrington's case.

Dr. Ham: What was the lateral plate?

Dr. Harrington: The lateral plates also showed that this disease was progressive. During one phase in the development of the pleural fluid they revealed an interlobar fluid, which didn't remain localized, and spread so that it could be aspirated. I think this is what was interpreted as an interlobar fluid, by the x-ray man.

Dr. Ham: It seems to me that this is rather a rapid and progressively fatal process to be explained on a basis of T.B. or a lymphatic disease. You would think in either of those conditions that you would have had more prolonged symptoms and a gradual wasting with the T. B. to be fatal, whether it was primarily the glands or what-not. You would also expect eventually to have gotten positive sputum. The glands of T.B., per se, I don't think, would cause fatality in this way.

Now, there was not a great deal said about the left side. There is some infiltration there. They suggested the possibility of metastatic process, which could be explained, of course, primarily on the malignant process.

With the lateral plate, too, it suggests atelectasis, in the middle lobe, and probably some fluid, too.

So I rather feel that more likely it is a carcinoma of the primary kind in the bronchus.

As to the lesion in the hand, there isn't enough detail given to be sure about.

Dr. Cutts: I should like, also to put myself down as favoring mediastinal tumor of some sort, with extension into the lung, either malignant lymphoma or carcinoma. I believe, probably, that the pulmonary condition and the neurological changes will be connected, because there is commonly a sequence of events which infection or tumor of the lung is the first and secondary cause

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CLINICOPATHOLOGICAL CONFERENCES

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to the brain.

DR. CLARKE: The head was not opened; I can tell you nothing about that. In each pleural cavity, there was more than a litre of fluid. Both lungs were collapsed from the pressure of fluid, and almost airless. On the right, the lung is described as having numerous small areas of necrosis, which I gather from the wording was a grayish, whitish material. Evidence of fibrosis was interpreted as being tuberculosis. The opposite lung had no necrosis, but there were numerous small nodules 2 or 3 m. m. in diameter, scattered throughout the lung.

The mediastinum was negative. There was nothing in the mediastinum, except some rather small lymph nodes that showed anthracosis. There were a few small scattered nodules in the liver.

When we came to the microscopic examination, we found that all of these tiny nodules in the lung are composed of a tumor. I forgot to say that there was no bronchial tumor demonstrable.

We have multiple tiny tumors scattered throughout the lungs, with no point of origin evidence.

Now, I shouldn't bore you with the disagreements of pathologists, but there are two possibilities under those conditions.

First of all, there is metastatic carcinoma, which is variously described as a carcinoma lymphangitis or diffused infiltrative lymphangitis metastases. This simply means that certain tumors metastasize, by way of the lymphatics, and the two organs are involved. The majority of such cases are found in the stomach.

Now, it is notorious that carcinoma of the stomach is frequently difficult to recognize grossly. There is a diffuse infiltrative type that causes little, gross distortions of the stomach. So that some writers maintain that in those at which no primary was found, it was just a mistake; it was overlooked.

Well, now, in our particular case, there is no description of the stomach. The gastrointestinal tract tends to be normal. Now, we depend upon microscopic findings to check things that are missed grossly, when we come to go over the microscopic sections, so that we have no very convincing evidence. There is another idea about these tumors that they are primary in the lung. These tumors have some distinctive features. The tumor cells tend to line the alveolar sac, so that we have large cells here (indicating) and the thing is essentially a normal lung, except for the lining. They frequently secrete mucous in the lumen.

In some cases of that sort of histology, with no evidence of malignancy, they are called adenomatosis of the lung. It is compared to a similar disease found in sheep. In addition to this rather distinctive lining of the alveolus, there is one point in this particular case that, in my opinion, is in favor of this primary origin of the lung, and that is, the lymphatics in the lung are not particularly involved in the carcinomatous lymphangitis; about the small blood vessels, you find the lymphatics stuffed with tumor all through the lung. There is no such lymphatic involvement in this lung. The only lymphatic involved in this lung is in the pleura which is metastatic.

In my opinion, we have alveolar carcinoma of the lung. When I use that term, I am only using a word that is descriptive and it doesn't necessarily originate from the alveolar epithelium.

I think that this patient had a primary carcinoma of the lung, with metastasis of the liver.

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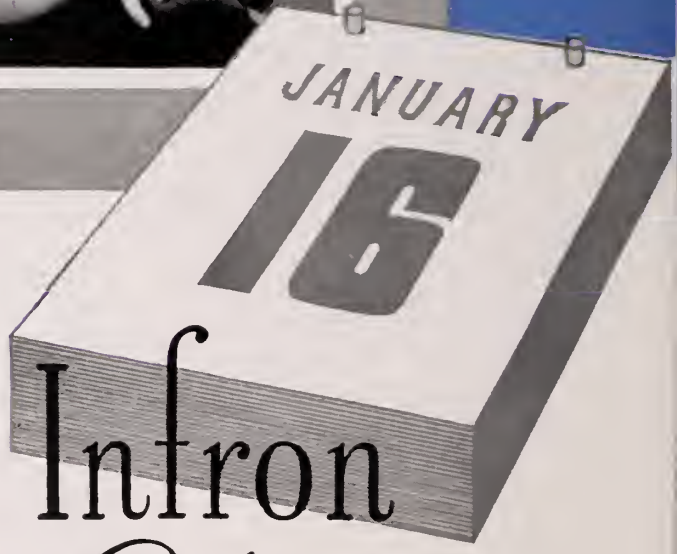
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HOSPITAL ASSOCIATION OF RHODE ISLAND

Report of the Annual Meeting

At the annual meeting of the Hospital Association of Rhode Island which was held at St. Joseph's Hospital on December 6th the following officers were elected to serve for the year 1947.

President, Oliver G. Pratt, Director, R. I. Hospital

Vice-President, William Sleight, Asst. Director, Homeopathic Hospital

Treasurer, Norman Wigglesworth, Asst. Controller, R. I. Hospital

Secretary, Francis C. Houghton, Business Manager, Butler Hospital.

Formal appreciation was extended to the retiring President, Leroy Cox, Superintendent of the Woonsocket Hospital, for his outstanding work of the past two years.

In a review of the year 1946 it seems fitting to list some of the problems which have faced the Association and its members, both personal and institutional, as well as to take a brief look at those issues which must be considered in the year just commencing.

As an organization we have grown slightly in stature, having accepted nine new members during the year and having lost five, two by death and three by resignation.

As an organization we have considered personnel policies and practices for hospital employees. The matter of salaries has been freely discussed and the recognition that they should be and were increased was weighed against the additional cost to patients. In considering the entire subject of increased hospital costs, the viewpoint and pocket book of the consumer of hospital services has never been neglected.

The allowance for Workmen's Compensation cases has likewise been studied. In view of rising costs and consequent inadequate allowance for this type of case it is planned to introduce legislation during the coming year which will more nearly permit hospitals to receive proper compensation.

It was learned during the year that Hospitals in many of the Atlantic States receive discounts from normal business rates from their suppliers of telephone service. Steps have been taken to obtain such a discount for the Hospitals of this State.

The Hospital Survey and Construction Act which was passed by Congress during the year provides a whole new set of problems to be met and properly handled. This Association is backing the State Department of Health in this respect and when the work has been completed the citizens of Rhode Island should have a clear inventory of their hospital facilities as well as a picture of their future needs, and perhaps a portion of the cash needed to meet such needs.

Since the Hospital Association cannot take any action that is binding upon its individual institution members, there are a series of problems which each member has had to contend with during the year and in which each has been aided through group discussion.

In this category personnel shortages have received much attention. United efforts have been made to recruit hospital workers. At least two hospitals now have full-time personnel directors. It is hoped that their advice and experience will be of benefit to the Association within the new year.

Shortages of various food items, construction materials, medical supplies and equipment have had and still have to be overcome. Substitutes and makeshifts have been used. New and vital construction has been held up.

Although the income of most hospitals has increased and in many cases reached an all time high, expenses have usually climbed faster with the result that most institutional members of the Association have ended the year with an outstanding deficit.

Several of the hospitals have been conducting fund raising campaigns to add new and more modern facilities. Modern in this case means in the sense that the facilities will save more lives, get people well more quickly and more surely. When the campaigns were started building costs were lower than at present. The result is that although the original goal may have been reached the hospital is still in need of additional funds. Here is a real problem which must be faced in the new year.

The Blue Cross of Rhode Island, which holds membership in this Association, has done an outstanding job both for the citizens and for the hospitals of our state. The Rhode Island Blue Cross

continued on next page

leads all the states of the country in having enrolled the highest percentage of eligible members. A problem still unsolved, but of concern to the Blue Cross, to the Hospitals, to the physicians and to the citizens of Rhode Island is that of a plan for medical and surgical care similar to the Blue Cross Hospitalization Plan. It is to be hoped that 1947 may become the inaugural year for such a program.

Doubtless other and new conditions are ahead of us. Some of the conditions will tend to solve the puzzlers of 1946 and some will pose new questions. The Hospital Association of Rhode Island anticipates that in this new year it may be of greater benefit to its members and thus to its fellow citizens than ever before.

R. I. H. HONORS CHIEFS OF STAFFS

The Active Staff of the Rhode Island Hospital on December 10th, at the Narragansett Hotel, staged a most agreeable and courteous good bye to the retired and retiring Chiefs of Staff.

It was a particularly informal and happy occasion, when two hundred doctors, the President and several members of the Board of Trustees, the Director of the Hospital and others, gathered to do honor to those twenty-four men who largely have guided the professional destiny of the Hospital during recent years.

The "Festival Chorus" functioned with its usual vim and harmony; there came to many a listener the familiar line, "age cannot wither—nor custom stale his infinite variety", or perhaps to others the more modern phrase—

"'At-a-boy! Bert!"

The after dinner speakers (unavoidable on such occasions and voted average good that evening) were presented in happy vein by a toastmaster nimble of wit and with agile and retentive brain for verse. They, in turn, discussed the past and present of the Hospital and were followed by Mr. Pratt, the Director, who thrilled the audience with a vividly alluring picture of its future. Generous applause was offered in response to these efforts, which it was evident were appreciated and enjoyed.

Then came the evening's high spot as Mr. Gerry, new President of the Board, presented memorials, diplomas or what-nots, to the guest Chiefs; with well chosen and pointed words, he gave each to understand that he personally had been "something". The Staff opinion of its new Commanding Officer incidentally, may be summed up thus: "Keep an eye on him, as he surely will on us!"

The men thus honored that evening felt deep appreciation for the genuine friendship shown by their fellows and expressed the hope that this, together with an abiding loyalty, might pass on to their successors and to the ever greater Rhode Island Hospital.

The final universal comment on this truly wonderful occasion was "It deserves an encore."

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BOOK REVIEWS

SYNOPSIS OF PATHOLOGY, By W. A. D. Anderson. 2nd Edition, Illustrated, 741 pages. C. V. Mosby Co., St. Louis, Missouri. 1946.

This Synopsis of Pathology is concise but comprehensive and is intended for medical and dental students as well as for the clinician. The essentials of the subject are well presented and patterns of disease are not obscured by a maze of detail. For finer detail and variations in disease processes the author refers the students of medicine to the many fine larger textbooks of pathology.

The organization of the book appears satisfactory. The first part deals with pathology in general and the second part deals with the pathology of special systems.

The volume is full of illustrations most of which are excellent. 15 plates are in color.

At the end of each chapter is a carefully selected list of references.

Though a thorough student of medicine could not possibly limit himself to a synopsis of this kind, especially in the vast field of pathology, nevertheless, the volume is an excellent source of reference material and is highly recommended.

MICHAEL DIMAIO, M.D.

THE MANAGEMENT OF FRACTURES, DISLOCATIONS AND SPRAINS. By John Albert Key, B.S., M.D., and H. Earle Conwell, M.D., F.A.C.S. Fourth Edition, pp. 1322 with many new illustrations. Cloth, $12.50, The C. V. Mosby Company, St. Louis, 1946.

The fourth edition of Key and Conwell's book, one of the standard treatises on the treatment of fractures and dislocations, has been revised to incorporate the newer methods and techniques in in the treatment of bone and joint injuries, including those evolved during the war. The principal changes have been made in the sections on the spine, the hip, and on compound fractures. Approximately 200 new illustrations have been added throughout the book.

In the chapter on "Compound Fractures and War Wounds", the authors state: "(We) now debride all compound fractures, except those caused by high-speed bullet wounds. These are not debrided because the bone is comminuted and such fractures tend to do better if treated as simple fractures, except that the wound is painted with an antiseptic and the patient is given sulfathiazole by mouth." There are many surgeons who will take issue with this statement. Many innocent-appearing perforating bullet wounds of the extremities were found to conceal extensive soft tis-

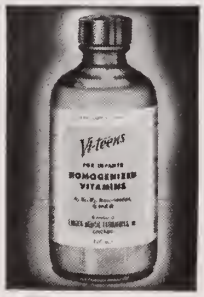
continued on page 51



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He distinguished himself as editor of the American edition of Gray's "Anatomy" and as author of the widely esteemed "Manual of Surgery". Because of his knowledge and genial wit, visiting physicians and surgeons seldom missed an opportunity to attend his clinics, and his surgical teaching has permeated every portion of the civilized world.



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BOOK REVIEWS

continued from page 48

sue destruction during the war, and required thorough debridement.

The authors advise the local application of sulfanilamide or sulfathiazole powder, preferably a mixture of both, in compound wounds. This is a controversial practice, and extensive studies in the Army hospitals failed to show this procedure to be of value in the healing of compound wounds. In general, wound healing appeared to be delayed by the local implantation of sulfonamides.

In describing Dickson and Diveley's technique of closure of chronic osteomyelitic wounds after thorough saucerization, the authors state: "Two days before operation the patient is started on—penicillin (1,000 units every 3 hours)." Obviously this is a typographical error, *10,000* units being meant. The present tendency is to use larger doses (25,000 to 50,000 units every 3 hours) of penicillin.

The authors place inadequate emphasis on the role of x-ray examination in the diagnosis and treatment of fractures, and state that "a large percentage of fractures can be adequately diagnosed and even treated without the aid of x-ray." They present the use of wooden splints in fractures on the forearm and wrist, which may give a false feeling of security to the general practitioner in the immobilization of certain of these fractures. The reproductions in the book are numerous and good, although the clarity of many of them could be improved to advantage.

In general, Key and Conwell's book is deservedly one of the most popular and widely read texts on fractures and dislocations, and is a valuable reference for both the orthopedic and general surgeon, as well as for the general practitioner who has occasion to treat bone and joint injuries.

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DISTRICT SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

A meeting of the Newport County Medical Society was held at the Newport Hospital on Tuesday evening, November 26, 1946.

The meeting was opened at 8:57 p m., with Dr. Alfred M. Tartaglino presiding.

The minutes of the October meeting were read and approved.

There was no old business.

A communication was received from the Camp and Hospital Committee of the Newport Chapter of the American Red Cross requesting a donation towards Christmas gifts, which are provided for the patients at the Newport Naval Hospital. Upon the motion of Dr. Norman M. MacLeod, which was seconded and passed, the matter was referred to the president and treasurer with power.

The speaker of the evening, Capt. Robert E. Baker, MC, USN, Chief of Surgery at the Newport Naval Hospital, was then introduced. Taking for his subject, "Early Ambulation," Dr. Baker explained his experiences, both before coming to Newport and in his capacity as Chief of Surgery at the Newport Naval Hospital, with the early activity of post operative patients. In a very unbiased and complete discussion of the pros and cons of the matter and with several amusing anecdotes, which had resulted from over enthusiastic application of the principle of early ambulation, he covered the field with fairness and without being dogmatic. He listed the advantages which he felt resulted from having patients out of bed early. He listed a number of very definite contra-indications to early arising, and he stated that his policy had been to encourage patients, that he felt were suitable for early rising, to get out of bed fairly early, but that no patient was forced out of bed before he was willing to do so.

A question period and general discussion followed the reading of Dr. Baker's paper.

The meeting adjourned at 10:00 p. m.
A collation followed.

Respectfully submitted,
HENRY W. BROWNELL, M.D., *Secretary*

KENT COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Kent County Medical Society was held at the Tollgate, Westcott, November 14, 1946, at 5:00 P. M. Dr. Merrill presiding, motion was made that the reading of the minutes of the last meeting be dispensed with.

Motion was then made by Dr. Tefft that the chair appoint a nominating committee for election of officers for the ensuing year at the December meeting. Dr. Merrill then named Dr. Fenwick Taggart, Dr. Royal C. Hudson and Dr. George Farrell as nominating committee. The chair entertained the motion that the next meeting be the annual meeting and scheduled for December 12.

After discussion motion was made by Dr. Fernand Hemond that the subject of contribution to the Community Chest be tabled until the annual meeting.

Dr. Merrill Gibson was then introduced and spoke on vagotomy in the treatment of peptic ulcer, a subject of very timely interest and importance. A rising vote of thanks was given Dr. Gibson for his excellent talk.

The meeting was adjourned at 6:00 P. M.

Respectfully submitted,
JEANNETTE E. VIDAL, M.D., *Secretary*

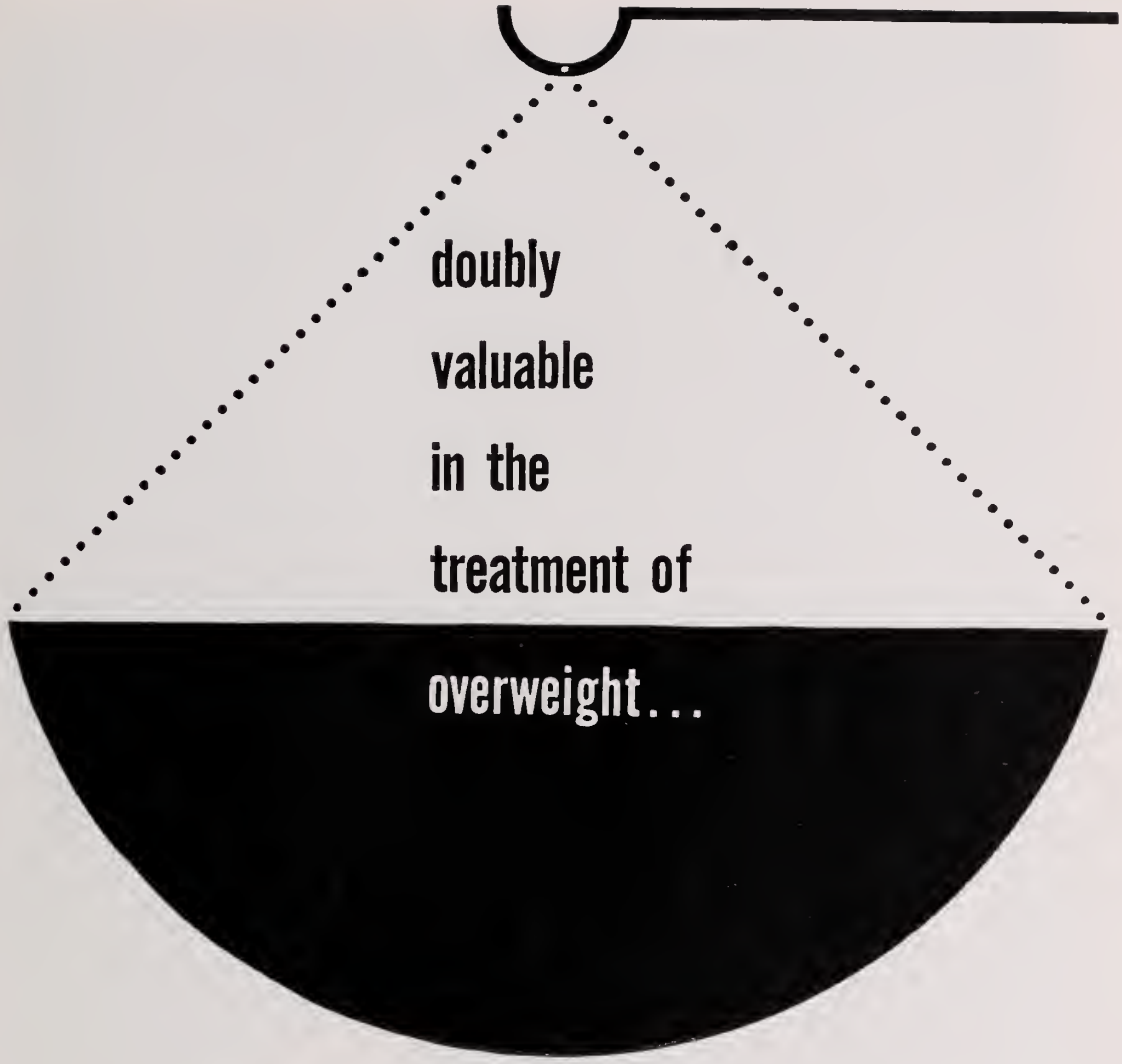
PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, December 2, 1946. The meeting was called to order at 8:30 p. m. by President Paul C. Cook.

The minutes of the previous meeting were read by the secretary.

The secretary reported for the executive committee that in accordance with the by-laws it had prepared a slate of officers for nomination at the annual meeting of the Association on January 6, 1947, and that any counter-nominations must be made in writing, signed by ten members of the Association and delivered to the secretary at least

continued on page 54



In a recent clinical study, Hawirko and Sprague* found that *Dexedrine* (*d*-amphetamine) exerts two beneficial actions in the treatment of overweight:

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PROVIDENCE MEDICAL ASSOCIATION

continued from page 52

ten days prior to the annual meeting. He reported the proposed slate as follows:

President	Guy W. Wells, M.D.
Vice President	Philip Batchelder, M.D.
Secretary	Daniel V. Troppoli, M.D.
Treasurer	J. Murray Beardsley, M.D.
Exec. Com. 5 yr. terms	Paul C. Cook, M.D.
	Charles Bradley, M.D.
Member of Council of R. I. Medical Society (2 year term)	B. Earl Clarke, M.D.
Trustee of R. I. Medical Library (1 year term)	Lewis B. Porter, M.D.

Delegates to the House of Delegates of the Rhode Island Medical Society:

Robert Baldridge, M.D.	Edward Famiglietti, M.D.
Alex M. Burgess, M.D.	Peter F. Harrington, M.D.
Peter Pineo Chase, M.D.	William A. Horan, M.D.
B. Earl Clarke, M.D.	Albert H. Jackvony, M.D.
G. Edward Crane, M.D.	Herman A. Lawson, M.D.
Frank B. Cutts, M.D.	Arthur E. Martin, M.D.
William P. Davis, M.D.	Frank I. Matteo, M.D.
Paul C. Cook, M.D.	Patrick I. O'Rourke, M.D.
Daniel V. Troppoli, M.D.	Edwin B. O'Reilly, M.D.
Louis I. Kramer, M.D.	Donald L. DeNyse, M.D.
Edward A. McLaughlin, M.D.	Robert Drew, M.D.
	U. E. Zambarano, M.D.
Guy W. Wells, M.D.	Russell R. Hunt, M.D.
Philip Batchelder, M.D.	Frederick A. Webster, M.D.
Michael O'Connor, M.D.	David Freedman, M.D.
John C. Myrick, M.D.	

Dr. Edward S. Cameron, chairman of the Committee on Smoke Abatement, reported on the introduction of a new city ordinance to control smoke. He briefly reviewed the developments of the ordinance and the fact that a hearing had been held this day before the City Council Committee.

The secretary reported that the Executive Committee recommended for election to active membership in the Association the following physicians: William J. H. Fischer, Jr., M.D.; Robert L. Garrard, M.D.; Vahey M. Pahigian, M.D.; James A. Reeves, M.D.

Dr. Guy W. Wells moved the unanimous election of these nominees. The motion was seconded and passed.

Dr. Paul C. Cook introduced Dr. Vincent J. Oddo who presented a case report on "Simple Cyst of the Renal Pelvis."

Dr. Oddo pointed out that cysts in the region of the renal pelvis are relatively rare. Pain in the kidney region is a constant symptom with this abnormality. A case was presented which was very well illustrated with slides of x-rays taken before and after surgical removal of the cyst.

Dr. Cook presented Dr. Fritz Behrendt of the State Hospital for Mental Diseases who spoke on "Treatment of Hypertension with Rice Diet." This study was conducted at the State Infirmary on 17 female hypertensive patients with diastolic pressures of 110 or over. They were observed for a control period of six weeks and then half of them were put on a rice diet. This consists of any kind of rice without salt, milk or fat. Fruits and fruit juices are taken and sugar and honey may be taken. Vitamins are added. On the diet there was reduction in blood pressure, particularly in the systolic component. Patients seemed to respond whether or not there was evidence of some renal disease.

The final presentation of the scientific program was given by Dr. Joseph N. Corsello, former assistant superintendent of the State Sanitorium, whose subject was "Primary Bronchogenic Carcinoma." A study of 47 cases, which were observed over a 13-year period at the Wallum Lake Sanitorium, were analyzed. In all instances, except one, the diagnosis was made ante-mortem and in 41 of the 47 cases, there was histologic proof of the diagnosis. In only 14.8 per cent of the cases, was the diagnosis suspected prior to admission to the sanitorium. Physical examination was of limited value in making the diagnosis and the x-ray showed a highly variable picture. It is of some interest that in 80 per cent of cases, the growth occurs in the trachea or major bronchi and is accessible to bronchoscopic examination. In 9 of the cases, total pneumonectomy was performed and of that total 3 are now alive and well. Forty-one of the group are known to be dead. Because of the insidious growth of these tumors, Dr. Corsello pointed out the inevitable high mortality and indicated that the only hope of improvement lay in earlier diagnosis with prompt investigation of symptoms and perhaps in the use of x-rays from mass surveys for tuberculosis to pick up pre-clinical carcinomas.

The subject was briefly summarized by Dr. O'Brien and discussed by Drs. Ham and Batchelder.

The meeting adjourned at 10:30 p. m.

Attendance—82.

Collation was served.

Respectfully submitted,

FRANK B. CUTTS, M.D., *Secretary*

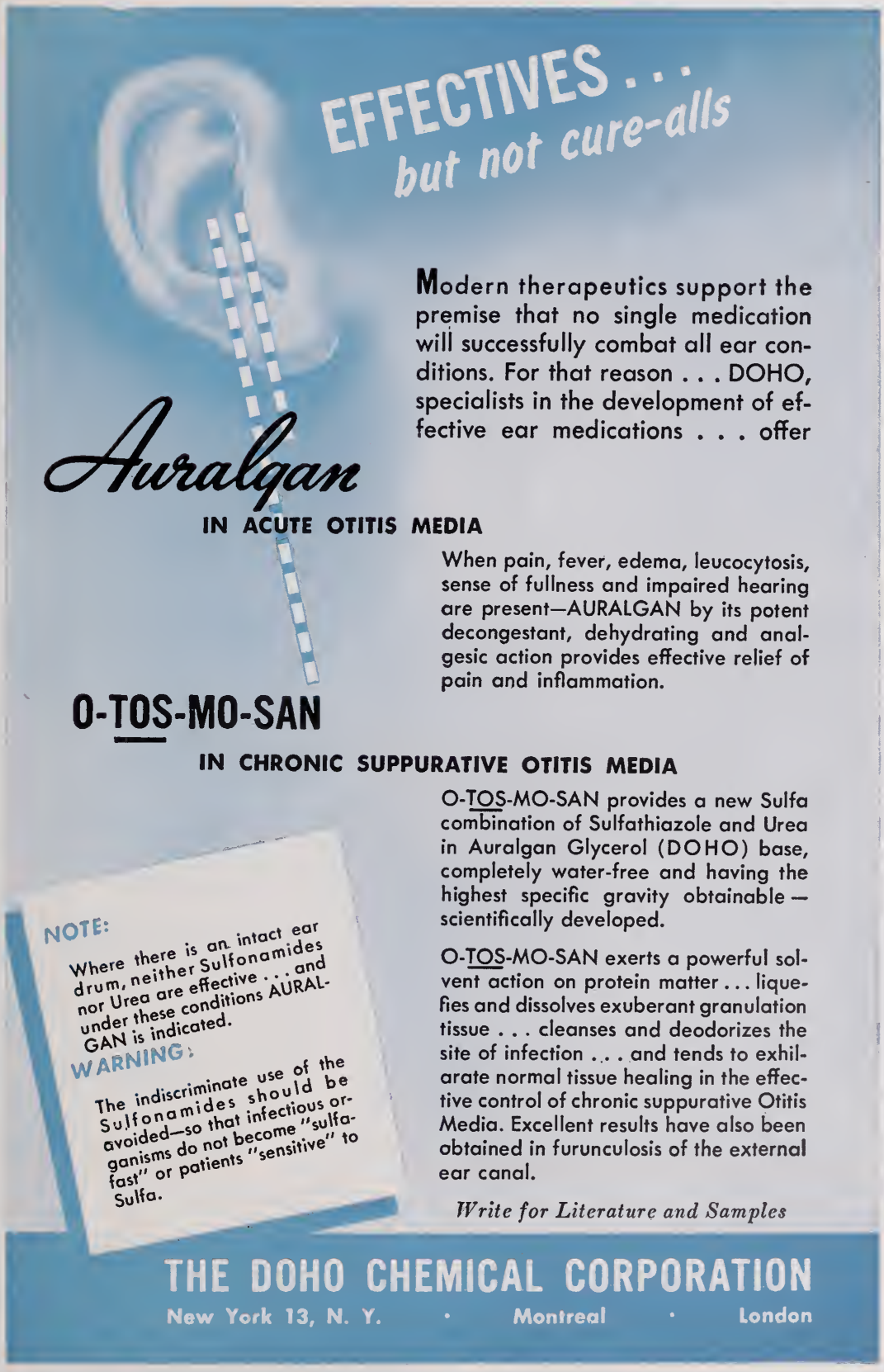
PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting was called to order by President Dr. William Kalcounos in the Nurses' Auditorium of the Memorial Hospital at 9:00 p. m. November 21, 1946.

The minutes of the previous meeting were read and accepted.

The applications for membership in the Pawtucket Medical Association of Dr. Bert Simmons Jeremiah and Dr. Henry Edward Turner were unanimously approved after they had been submitted to ballot. The Secretary reported that the Standing Committee had approved Dr. Louis E.

continued on page 56


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PAWTUCKET MEDICAL ASSOCIATION

continued from page 54

Hanna for membership in the Association and his application will be voted upon at the next meeting.

A motion was made and seconded that the Medical Association note in its records that recognition accorded a member and present Councilor of the Association, Dr. James L. Wheaton, by the trustees of the Memorial Hospital at its annual meeting wherein he was elected President of the Board of Trustees.

A motion was made and seconded that action regarding a request from the Community Chest be tabled.

The meeting was then turned over to Dr. Henry Hanley who had arranged the program. Dr. Hanley observed that there was much in the art of medicine as well as in the science of medicine and for that reason he had asked some of the older members of the Society to discuss some of their interesting and unusual cases. Dr. Irving Farrell, Dr. Earl Mathewson, and Dr. Albert Gaudet speaking for Dr. E. A. Cormier, thereupon discussed a variety of cases that adequately fulfilled the requirement of being interesting and unusual.

The meeting adjourned at 10:15 p. m. and refreshments were served.

The following members were present: Drs. Barry, Beaudoin, Boucher, Doll, Irving Farrell, Ferguson, Foster, Gaudet, Henry Hanley, Frank Hanley, Hennessey, Hecker, Stephen Kenney, Krolicki, Laverning, Lussier, Laurelli, Mara, Mathewson, McCaughey, McGinn, O'Brien, Ronne, Senseman, Smith, Sprague, R. T. Stevens, L. Turner, Umstead, Webster, Wheaton, Zolmian, Eddy, and Moor.

Respectfully submitted,

KIERAN W. HENNESSEY, M.D., *Secretary*

PHOTOS BELOW: Top row, speakers at annual dinner of the Providence Medical Association. Left to right—Dr. Herman P. Grossman, chairman of entertainment committee, Dr. Paul C. Cook, president, and Dr. Guy W. Wells, vice president. Bottom photo shows Dr. Cook awarding President's golf trophy to Dr. Harry Darrah.





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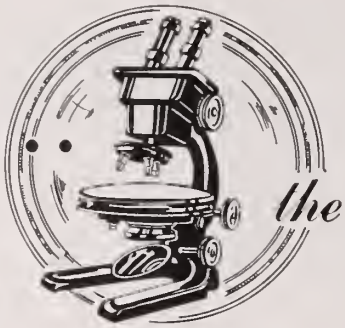
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THROUGH . . . the Microscope



No Danger?

Although Governor Green of Illinois, speaking to the secretaries and editors of the state medical associations at their conference in Chicago on December 8, expressed the opinion that the "danger" of the adoption of a plan to socialize medicine was no longer present, we are inclined to be less optimistic. "It is natural," said the Governor, "that in a period when collectivist philosophies were sweeping the world proposals for some sort of state medicine . . . should take hold with many people." These proposals found favor, he added, because they were offered in conjunction with "other sound health measures which have your support".

Sickness Compensation

Disability pay for time lost from work because of illness is being paid California workers as in Rhode Island. Under the California law commercial insurance firms and voluntary insurance plans can compete with the state-organized Unemployment Insurance Disability Fund for the insurance provided they meet the minimum benefit payments from $10 to $20 a week up to a maximum of 23 weeks a year as authorized by the law. The New Jersey legislature will consider a plan for disability insurance this session with the major debate apparently centering on whether it will be a state operated program, like Rhode Island's, or a plan whereby private insurance companies will compete for the business meeting at least the minimum state provisions now suggested at $7 to $22 a week with a maximum of 13 weeks for each period of disability. Both California and New Jersey have profited by Rhode Island's experience to the extent of eliminating maternity benefits.

Fellowships

The Surgeon General of the U. S. Public Health Service has announced that applications for Fellowships in post-graduate public health training for physicians for the school year beginning next fall will be received anytime prior to May 1. These fellowships aimed for the specific purpose to help fill hundreds of vacancies existing in State and local health departments throughout the country are intended for newcomers to the public health field, and they are made possible by a grant of more than two hundred thousand dollars from the National Foundation for Infantile Paralysis.

Milk

The Milk Industry Foundation has recently published a new survey to show how the United States has grown to be the greatest of dairy nations. Of particular interest was the increasing importance of Rhode Island as a dairy state. Pertinent facts about our so-called "littlest" state: Our 21,000 cows produce $5,295,000 cash farm income for dairy farmers. Yearly milk production is 62 million quarts. Principal use of this milk in addition to fresh milk was for making nearly 2¼ million gallons of ice cream.

Medical Service Conference

The 20th Annual Meeting of the National Conference on Medical Service will be held at the Palmer House, Chicago, on February 9. The program will include discussions in the fields of national affairs, economics, and medical education. All physicians are invited to attend, and there is no registration fee.

Meetings

It is not too early to make hotel applications for the American Medical Association meeting at Atlantic City starting the week of June 9. This is the Centennial Year for the AMA and the largest attendance ever at the national assembly is anticipated. And speaking of Atlantic City we are reminded that the American Public Health Association will hold its 75th annual meeting there the week of September 22.

Persons

Dr. Stanley Sprague, chairman of the R. I. Medical Society's committee on industrial health, is now president of the New England Council of the American Association of Industrial Physicians

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THROUGH THE MICROSCOPE

continued from page 58

and Surgeons. . . . Dr. Francesco Ronchese had an exhibit entitled "Hemangiomas — Should Treatment be Expectant or Active?" at the 5th annual meeting of the American Academy of Dermatology and Syphilology held in Cleveland last month. . . . Governor Kim Sigler of Michigan who was publicized in a popular national magazine this month as a man who gets things done has as his first assistant Dr. Eugene C. Keyes, a Detroit resident who is a physician, dentist and attorney. . . . For those who are historically minded it is a matter of record that the first American degree of doctor of medicine was conferred by the General Court of Rhode Island in 1663 when Captain John Cranston was licensed to practice "Chirurgerie" and to administer "physick".

MANY AMERICANS IMMUNE TO MUMPS

Thirty per cent of the American people probably have had mumps without knowing it. The result has been a high degree of immunity to epidemics of this common, but sometimes quite serious, disease of childhood. Such is the conclusion from studies of 50 groups of children and adults conducted by University of Pennsylvania and Harvard University medical scientists under a contract with the Commission on Measles and Mumps of the Surgeon General's Office, United States Army. Mumps and measles usually are paired as childhood maladies. Each is caused by a specific filterable virus. Both diseases are very contagious. One virus presumably is a widely disseminated in the population as the other. Yet the studies reported by Doctors Elizabeth P. Maris, John F. Enders, Joseph Stokes, Jr., and Lewis W. Kane, show that about 33 per cent of young adults have a probable acquired immunity to the disease indicating some past infection of which they were unaware. One attack of mumps is believed to protect an individual against further attacks of the virus for the rest of his life. Statistical studies have shown that whereas about 90 per cent of the American population suffer from measles at some time or other only 60 per cent are victims of mumps. The immunity of a person was determined by the so-called "complement-fixation" test of the blood serum with mumps virus cultivated in incubated chicken eggs, and also by a skin test with similar material. In this hidden reservoir of acquired immunity, mumps seems to bear some likeness to poliomyelitis, also a virus disease of children. It is believed that about 90 per cent of the population have had polio in a sub-clinical form at some time, with the result that they are permanently protected against it. The reasons why mumps should attack some persons in such a mild form that it is not recognized—it may amount to no more than a slight headache or an "out-of-sorts" feeling— is unknown. The technique of determining immunity may prove of considerable value in times of mumps epidemics when the relative susceptibility of a population can be determined before undertaking defense measures.



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RHODE ISLAND MEDICAL SOCIETY, NECROLOGY, 1946

RAYMOND G. BUGBEE, M.D., surgeon at Rhode Island Hospital for many years and athletic surgeon at Brown University since 1927, died February 3, 1946, in his 64th year. Dr. Bugbee was born in North Attleboro, Massachusetts, on December 11, 1882. He was graduated in the class of 1906 from Brown University, and in 1909 he received his degree of M. D. C. M. from McGill University Medical School. He was the first American Student at McGill University to win the Nood Gold Medal for diagnostic proficiency. Dr. Bugbee was a member of the Providence Medical Association, and he became a Fellow of the Rhode Island Medical Society in 1912.

EDWARD CAMPBELL, M.D., a practicing physician in Providence for forty-six years, died on January 26, 1946. Dr. Campbell was born in 1867 in County Tyrone, Ireland. He graduated with honors from the College of Physicians and Surgeons, Baltimore, Md., in 1899. Soon after that he came to practice in Providence, and became a member of the Providence Medical Association and the Rhode Island Medical Society in 1903. Dr. Campbell was one of the first of his profession to become interested in physiotherapy, and he specialized in that field for the last decade of his life.

IRVING SHERBURNE COOK, M.D., was born in West Wrentham, Massachusetts, on March 3, 1858. He was graduated in 1881 from Tufts College and from Harvard Medical School in 1886. Immediately after his graduation he took Dr. Nutting's place in Georgiaville and practised medicine there for 58 years, the rest of his life. In Smithfield he served in a public capacity as health officer for 32 years, on the school committee for 16 years, and an organizer of medical inspection of schools. He became a member of the Providence Medical Association and the Rhode Island Medical Society in February, 1912. Dr. Cook died September 9, 1946, at the age of 88 years.

JAMES AUSTIN GILBERT, M.D., died in Providence on May 17, 1946, at the age of 79. He was born in Wreck Hill, Somerset Bridge, Bermuda, April 4, 1867. At the age of 13 he was sent to Toronto, Canada, where he stayed until his second year in college, which was completed at Howard University, Washington, D. C., in 1891. He then entered medical school there, graduating in 1894, and interned at the Freedman's Hospital in Washington, D. C. Dr. Gilbert then came to Providence and engaged in general practice for over fifty years. He became a member of the Providence Medical Association and the Rhode Island Medical Society in 1894.

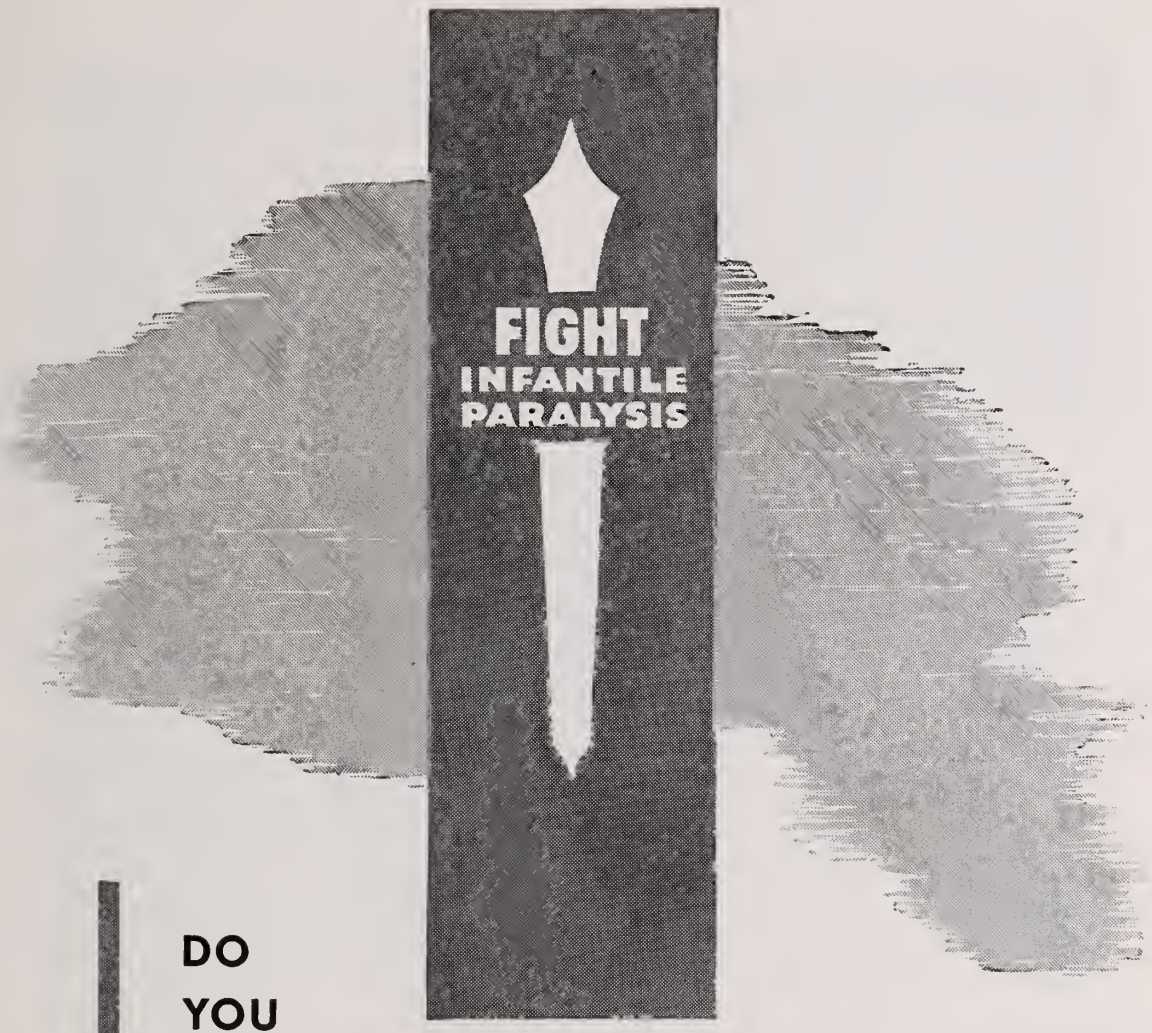
KATHRYN ANNE HARDY, M.D., was born in Auburn, New York, on February 16, 1911. She attended Syracuse University in 1928-1929 and the College of New Rochelle in 1929-1931 and received her doctor's degree from Tufts Medical College in 1935. Dr. Hardy gave up her medical career after her marriage until the war, when she began practice in Warwick. Dr. Hardy was a member of the Kent County Medical Society, the Providence Medical Association, and the Rhode Island Medical Society. She died on March 7, 1946, at the age of 35.

HOWARD FRANCIS KEEFE, M.D., was born in Providence, Rhode Island, May 4, 1898. His Bachelor of Arts degree was received from Boston College in 1920, and his Medical degree was granted by Tufts Medical College in 1924. Following the completion of an internship at St. Mary's Hospital in Philadelphia, Dr. Keefe established his office for the general practice of medicine in Cranston, where he practiced continuously until 1941 when his career was interrupted by illness. He became a member of the Providence Medical Association in 1927 and the Rhode Island Medical Society in 1943. He died on March 13, 1946.

MICHAEL BERNARD MILAN, M.D., died January 20, 1946. He was the oldest living practitioner in Rhode Island, born in Milford, Massachusetts, on March 16, 1862. He attended Amherst College and received his medical degree from Bellevue Hospital in 1892. He became a member of the Providence Medical Association in 1904, and he was also a member of the Rhode Island Medical Society. Dr. Milan came to Olneyville in 1893 where he lived until the time of his death.

MICHAEL JOSEPH O'NEIL, M.D., a practicing physician in South Providence for 30 years, died February 2, 1946 in his 72nd year. Dr. O'Neil

continued on page 66



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NECROLOGY, 1946

continued from page 64

was born on June 19, 1874, in Worcester, Mass. He received his medical degree from Jefferson Medical College in 1903. Dr. O'Neil was a member of the Rhode Island Medical Society.

JOHN MATHEWS PETERS, M.D., retired superintendent of the Rhode Island Hospital, died January 27, 1946, in his 83rd year. He was born November 2, 1863, in Syracuse, New York. After attending the public schools, he went to Phillips Exeter Academy, and then to Harvard Medical School, from which he graduated in 1887. Near the end of his two years' internship at the Rhode Island Hospital he was appointed superintendent of the Hospital in 1889, which was an unusual honor. He served in this capacity for forty-four years. Dr. Peters was president of the Providence Medical Association from 1900-01, and the Rhode Island Medical Society from 1919-20. He was also a member of the Providence Board of Hospital Commissioners from its creation in 1909. Dr. Peters was past president of the American Hospital Association, and the New England Hospital Association.

ALANSON D. ROSE, M.D., a pioneer physician in the Manton section of the city, died February 19, 1946. He was born on Block Island, June 13, 1866, and attended Worcester Academy and Albany Medical College, Albany, New York, from which he received his medical degree in 1889. He became a member of the Providence Medical Associaation and the Rhode Island Medical Society in 1904.



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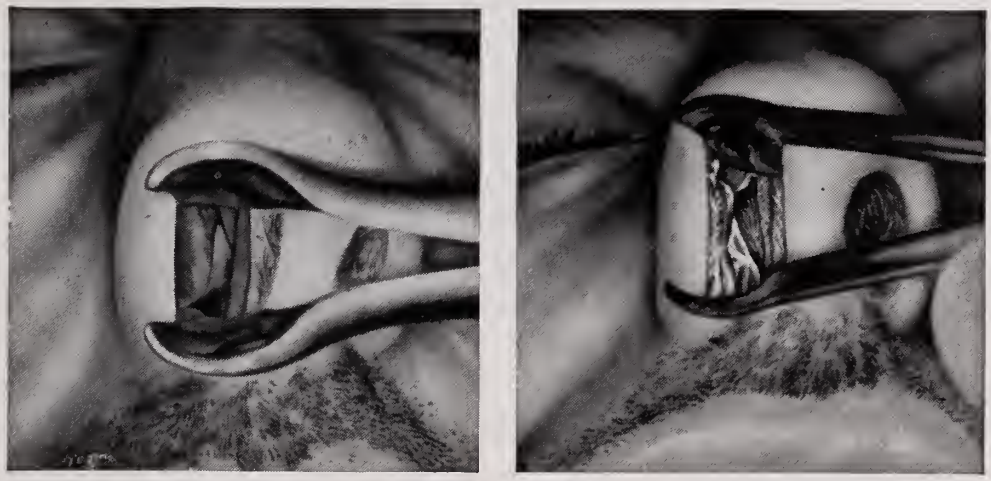
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* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60



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ARMY REPORTS ON USE OF STREPTOMYCIN

The new anti-infection agent, streptomycin, which is in the same general class as penicillin, appears effective in appropriate doses against more than half the infective bacterial organisms ordinarily encountered by surgeons, according to the report to The Surgeon General's Office from the Halloran General Hospital. Clinical studies of the use of the drug throughout the army have been submitted and evaluated at Halloran.

On the other hand, it apparently has specific poisonous effects when given over an extended period, and bacteria soon become resistant to it so that it probably can be used only once with maximum effect within a limited period on the same patient.

The drug became available only late in the war and is still scarce and expensive.

Army experience with the drug is probably the most extensive to date due to the ability to compile and follow results. Outside the services because of limited opportunities to observe results in large numbers there have been varied, and sometimes quite exaggerated, reports on its value and it often is referred to popularly as a "miracle drug." From the first careful observations of its effects have been carried out by army doctors by orders of The Surgeon General, and these are being continued. The findings to date are summarized in the Army Medical Bulletin of November 1946.

The observation of the ability of bacteria to develop resistance to the drug after a few days may be of particular importance at this time. The same has been noted in respect to both the sulfa drugs and penicillin, but apparently the phenomenon is more pronouced with streptomycin. In at least one case, test tube experiments showed, there was a 100-fold increase of the resistance of an organism in ten days. Given indiscriminately, the drug may lose any value for a particular type of infection in an individual for the rest of his life. Improper use may cause variation and selection in disease agents so that streptomycin is no longer effective for the infection where it is of greatest value at the present time.

Bacteria, on the basis of certain chemical reactions, ordinarily are divided into two classes—gram positive and gram negative. The new drug, in test tube experiments, seems effective in varying concentrations, against 60 per cent gram positive and 80 per cent gram negataive organisms ordinarily encountered in surgery.

Of paramount importance, is determination whether a specific micro-organism is susceptible to the drug before it is administered by mouth, by injection, or direct application.

The army experience bears out previous claims that streptomycin is of especial value in clearing up infections of the urinary tract, provided that the organisms causing the infections are susceptible ones. If the treatment is not entirely effective in three days ordinarily no good results can be expected from its continuation. In gonorrheal infection which has proved resistant to both sulfadiazine and penicillin outstanding results have been obtained.

Use in army hospitals gives no support to claims that the drug is of value in infections of the prostate. The drug is not concentrated in that organ.

It was found to have very little value against bone infecions, except when used in conjunction with surgery where there could be direct application.

Thus far streptomycin has not given dramatic results in peritonitis, but its continued use as an auxiliary treatment seems justified.

In various dysenteries due to susceptible bacteria considerable benefit has been noted, sometimes when the drug is given by mouth alone.

In septicemia—still provided that the organism responsible for the infection is a susceptible one—streptomycin has proved very effective, but it is still essential that unapproachable foci of infection be removed by surgery.

The substance has little value, so far as the army experience goes, against typhoid fever and it is apparently of no use in controlling carriers of this disease.

In undulant fever there have been apparent clinical arrests of the infection from the combined use of streptomycin and sulfadiazine after each drug given alone had failed. Further study will be required, however, before any valid conclusions can be reported.

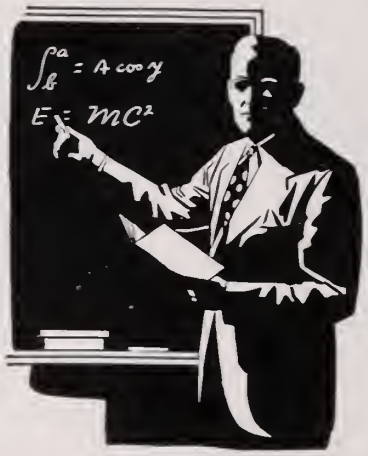
It is very effective against tuleremia, or rabbit fever, provided the specific organism responsible has been demonstrated in test tube experiments to be susceptible to the drug.

Up to date experience with only a few cases of meningitis have been reported and the results, in conjunction with other treatments, have been quite good. The Army doctors found, however, that it must be given by injection into the space between the thick membranes surrounding the brain and spinal cord and the brain or spinal cord tissue. Circulating in the blood stream, it cannot pass this barrier to reach the infecting organisms.

Excellent results have been obtained with direct application of the drug to infections of the external ear, the pleural cavities and the brain. Infections elsewhere will not reach local foci of infection in sufficient concentration to be effective.

One of the hopes of the medical profession has been that streptomycin would prove of some value against tuberculosis. The army experience neither confirms nor refutes this since a much longer series of investigations will be required before there can be any valid conclusions.

Balances against the demonstrated value of streptomycin in suitable cases are some apparently toxic effects. Some of these are probably due to impurities in the drug but others seem to be specific for the drug itself. The most serious of these is what seems to be an irreversible damage to part of the eighth cranial nerve which appears when streptomycin is given in large doses by injection for more than ten days. This means that one's sense of balance may be disturbed for a long time, with possible attacks of dizziness and nausea. This was found in two army cases. A third patient showed partial deafness, indicating that there had been a poisonous effect on the other portion of the eighth cranial nerve, which is the path of hearing. Toxic effects also were noted on the kidneys. All this demonstrated that the drug should be given only by physicians, and then only after careful consideration of the organisms involved and the safe dosage.



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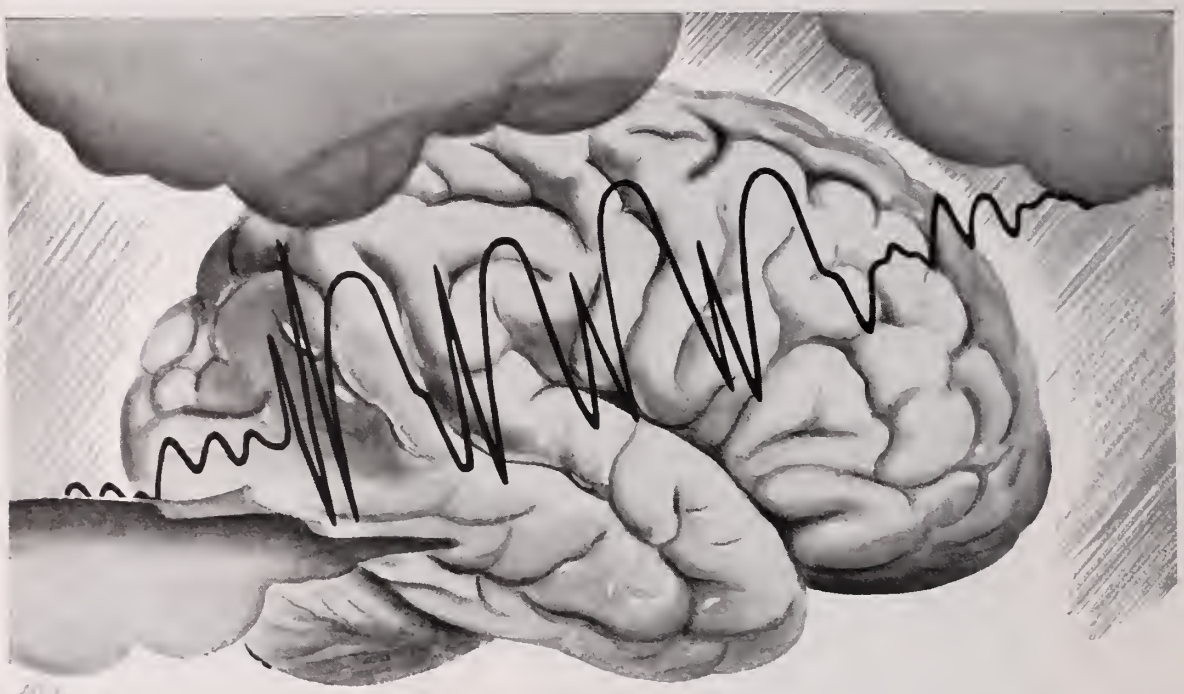
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*Frazer, J. G.: The Golden Bough, vol. 1, New York, Macmillan & Co., 1923



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Volume XXX, No. 2

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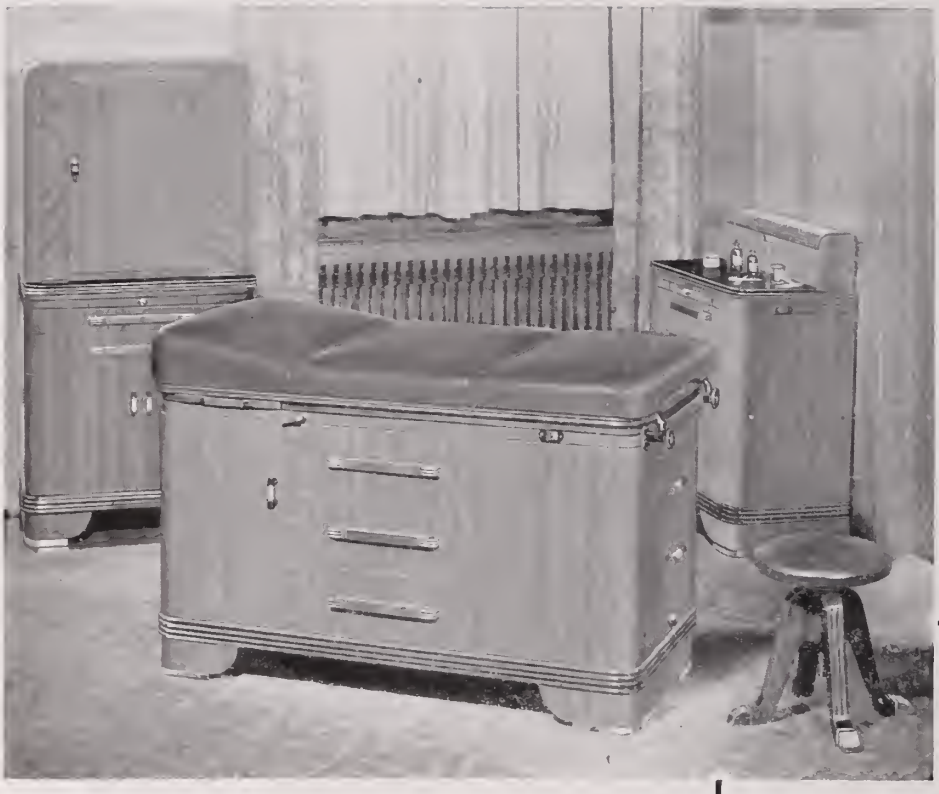
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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

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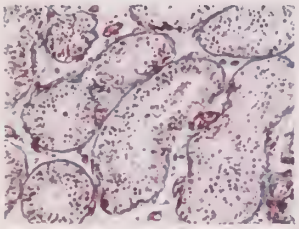
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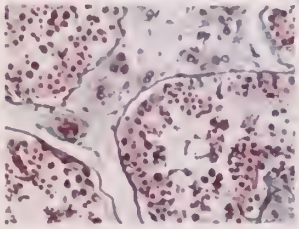
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1. McGovock, T. H.: Jl. Clin. Endocrin., 3:71, 1943.
2. Werner, A. A.: J.A.M.A., 132:188, 1946.



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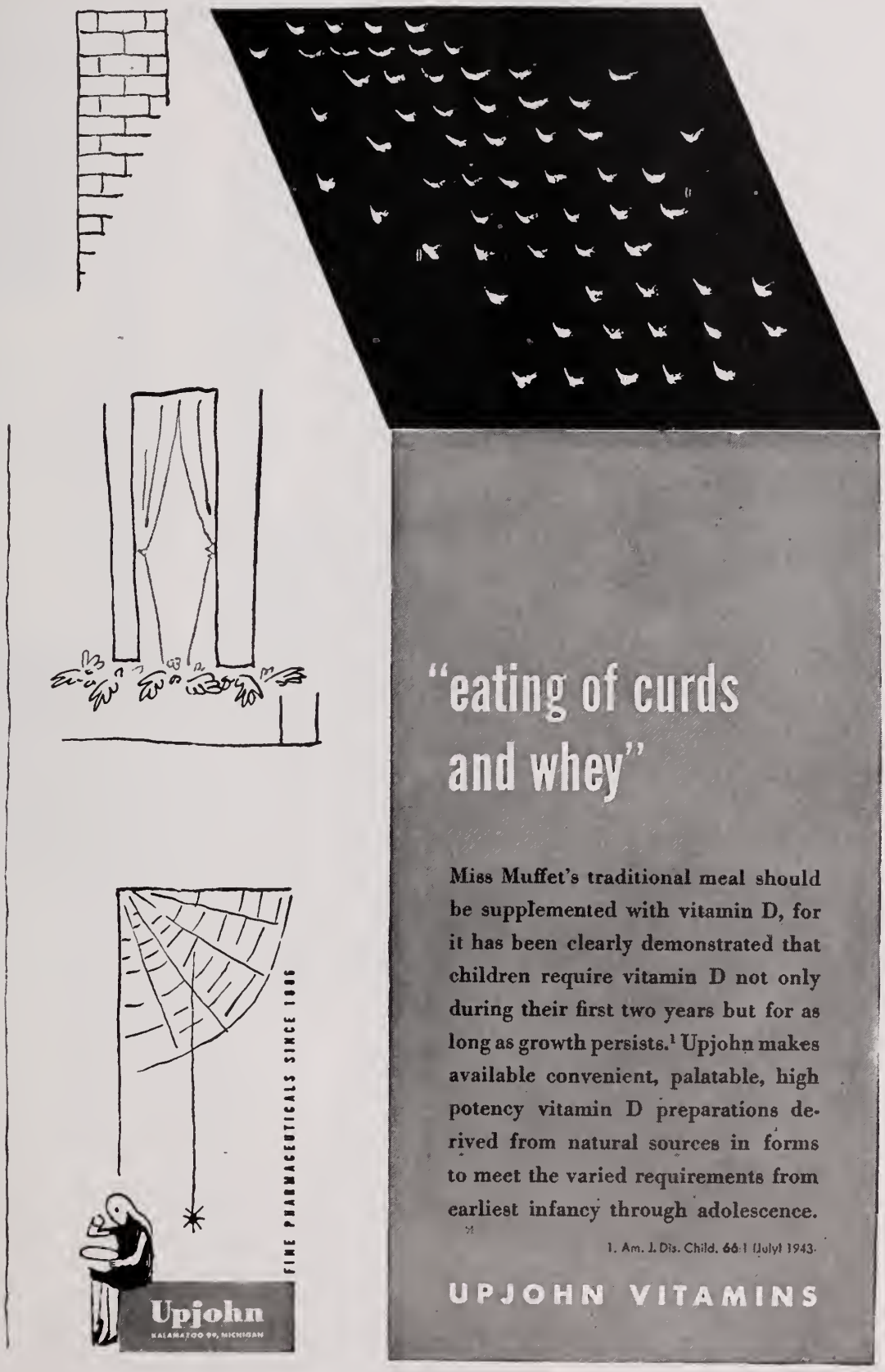
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Illustration by Andrew Loomis

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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXX FEBRUARY, 1947 NO. 2

RHODE ISLAND'S WATER POLLUTION PROBLEM*

PAUL C. COOK, M.D.

The Author. *Paul C. Cook, M.D., of Providence. President, Providence Medical Association, 1946.*

THE HIGHLIGHT for the Association the past year was the return of our colleagues from service with the armed forces following the conclusion of World War II. Our membership as we start the year 1947 is almost entirely that of physicians in civilian practice again, and we rejoice upon the return of these men to our community.

The Association has been mindful of its obligation to the men who left here to serve with the military forces. We have done what we could to help them re-establish their practice. Public display announcements have been carried in the *Providence Journal* at various times to list the office address and telephone number of the returned physician. Our committees have met with municipal authorities in the matter of zoning restrictions in areas where physicians have desired to locate, and with real estate agencies to seek possible office spaces. The exemption from Association assessment maintained during the war service was continued for each returning physician for a period of six months after he established civilian work.

These activities are not necessarily great, but they reflect a conscientious effort on the part of the Association to help solve some of the problems of the physician-veteran.

To relate all the various activities of the Association during the year would entail repetition of what will be presented to you in detail through various committee reports. However, I would like to recall to your attention some of the more important items. We have instituted action by the State Society for the development of better medical-dental relations, we have studied the possibility of a central telephone exchange, reports have been made to you on the question of fees for home and office visits in our district and of physicians available for day or night emergency calls. We have initiated action towards a fitting celebration of the Association's centennial next year, and our old original records have been microfilmed for better preservation. The Association's action in arousing the community to the need for more effective control of smoke pollution has resulted in civic action and more recently in the introduction in the Providence City Council of a better smoke ordinance.

The most important part of our activity, the presentation of scientific papers to our members, has received first consideration throughout the year. We have been fortunate in having had some outstanding speakers—Major General Hawley and Dr. Shields Warren come to mind as we look back. There has been an effort made to include speakers of our own locality, and those representative of our own institutions, on the programs. As in past years, we have had more material than we could use, and have been forced to defer some desirable papers to a later date. One of our most enjoyable evenings was the April meeting, when several of our members, newly returned from service with the armed forces, gave reports of their medical work and experience in widely scattered sections of the globe. The attendance at the meetings has been good. We have appropriated funds for the opening of the Library three nights each week for the convenience of the members.

In addition to the social gatherings that conclude our monthly assemblies at the Medical Library, our efficient Committee on Entertainment staged one of the finest annual dinner programs in our history. It is to be hoped that these functions will continue to expand and bring into closer contact socially the physicians of the Providence area.

Pollution of State Waters

In the time at my disposal this evening I am go-

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* Presidential address delivered before the Providence Medical Association at its 100th Annual Meeting, at Providence, January 6, 1947.

ing to consider a subject in which the Association has been officially interested during the past year through an active committee, and one which individually concerns us all, that of pollution of our State waters.

I wish to express my gratitude to Mr. S. Robert Preston for making available to me the records of the State Planning Board and to the *Providence Journal* for granting access to their files in the preparation of this talk.

The recent publication of the proposed plan of the Department of Health is most welcome as it promises to be a step toward abatement of this dangerous health situation.

Rhode Island is more closely associated with its waterways than any other state, surrounding Narragansett Bay as it does, and being endowed by Nature with an abundance of small rivers and streams. Both its tidal and fresh waters have been of great importance in the life of the State, economically and in other ways.

In rural districts water pollution is of little consequence. Streams can handle the small amount of industrial waste from scattered small mills without damage to themselves, sanitary waste seldom finds its way into them, and these waterways remain economic assets without sacrificing their recreational and health value.

The accumulation of population and industry in the relatively small area of our State has placed a burden on our waterways that has very seriously changed their character. They have, in many cases, been unable to cope with the amount of waste that has been put in them, and increasing amounts of industrial and sanitary sewage have been channelled through them into Narragansett Bay. I do not consider it necessary to give here extended proof of the pollution of the Bay and many of the inland waterways of the State. The facts are self evident. We all know that the upper Bay is grossly polluted. The most casual inspection leaves no doubt of it. The water is foul, offensive to sight and smell, often gleaming with oil scum, the shore line littered with garbage, smeared with oil, with unmistakable evidence that untreated sewage has been poured into it, particularly along the eastern shore below the mouth of the Seekonk. At low tide the conditions do not bear too close description—the sewage outlets of water-front estates, illegally piped into the bay are then plainly evident. Recently twenty-three such outlets were counted along a half-mile stretch of shore in what is considered a desirable residential section. They are a minor source of pollution, and are important mainly as they typify the disregard of the laws of the State in this respect. The main sources of contamination of the Bay can be classified in different ways. Geographically, they are sources within and without the State, and are of the same nature whether they arise in Massachusetts, in the industrialized Blackstone Valley, emptying industrial and sanitary sewage into the Blackstone River and the Seekonk, or in the Taunton and Fall River areas, discharging into Mount Hope Bay, or whether they originate wholly within our own State.

A considerable source of pollution is the dumping of refuse and sewage from ships in the Bay, particularly naval vessels. The Navy's shore installations at Quonset and Davisville have sewage treatment plants, but the large and small craft, from airplane carriers down, that are or may be berthed at Quonset or Newport, with crews well into the thousands, dispose of all their refuse in the State waters.

Types of Pollution

Another geographical division might be between waterways designed for public use as a source of drinking water and waterways used for industrial purposes. To give credit where possible, there is no evidence of any pollution of our public water supplies of any consequence. Classifying pollution by the nature of the polluting substance, we would have three types: that due to sanitary sewage, municipal or domestic; industrial, comprising the waste products of numerous types of industry that exist in Rhode Island, contributive in greater or less degree to stream and bay pollution; and lastly oil pollution, which should be considered separately from sanitary and industrial sewage. All these factors contribute to the condition which was so well summed up in the masterly statement in the editorial in the Rhode Island Medical Journal for June, 1946: "It can be taken for granted that Narragansett Bay is a nasty place." The causes of this increasing pollution may be summarized by saying that population and industry have far outstripped provisions made for the healthful and decent disposal of their waste products.

We might at this point briefly consider the oil problem. Some thirty years ago the various oil companies began to establish their plants on the shores of the upper Bay, until now Providence is the major oil port of the northeastern seaboard. Immediately a special type of pollution was introduced. Industrial and sanitary sewage render water unfit for marine life by their toxic action or by reducing the water's oxygen content. Oil is more destructive, both while on the surface, as a film, when the immature oysters in their free-swimming form are killed by it, and when it has settled to the bottom to unite with other contaminants and form a sludge that kills or renders unfit for food any shell fish that comes in contact with it. In 1939 the sub-committee on Wild Life of the State Planning Board reported the effects of oil polution on our marine life. Leased oyster grounds had dimin-

ished to less than one-fourth of their former extent, the financial return to this industry had fallen from a peak of two million dollars to about five hundred thousand, our other fisheries had suffered proportionately. Oysters had failed to propagate in our polluted waters, and spawn had to be imported from cleaner out-of-state sources. Surface oil had killed more of our wild ducks than all the hunters. There had been a continuous expansion of the contaminated area of the upper Bay, transforming "the once clean bottom to a mucky, foul smelling mud unfit for normal marine life of any sort. The range of foul bottom extends in places far beyond the restricted water zone."

The economic loss occasioned by oil and other contamintants of the Bay includes damage to the recreation industry, important in this State. Polluted water does not attract vacationists. Already, this business has suffered, and will suffer more if the present tendency continues. Aside from the financial loss, there is a more serious one: our residents are being denied, more and more, opportunities for healthful recreation that are theirs, of right, as citizens of a State with unequalled natural resources for many types of play.

Our other varied Rhode Island industries are being handicapped as well by water pollution—there is an inadequate supply of reasonably good water for their processes, and the means of disposal of their waste products is also inadequate. For these reasons Rhode Island is not an attractive place for new industries. None have come here for many years, and the likelihood of any braving the present conditions is slight.

The physical equipment in the State for the handling of industrial and sanitary sewage comprises sewage plants in Providence — handling a part of Pawtucket's sewage and that of North Providence; in East Greenwich; East Providence, serving a part of that town; Bristol, Warren and West Warwick. Cranston is building a plant which, at present, is partially completed and is in use for part of that city. The only means of disposal for industrial wastes has been to empty them into municipal sanitary sewers or convenient waterways. Industrial and sanitary sewage disposal are different problems: industrial wastes are chemical solutions and in the main interfere with the bacterial action which is the basis of sanitary sewage treatment. Industrial waste, then, can only be emptied safely into our sewage plants in limited amounts. The disposal of oil finding its way into sanitary sewers is limited by the same factor. The statement in the recent department of health plan for pollution abatement that the main sewage treatment plan of the State, that of Providence, is only 50 per cent as efficient as expected, is very disturbing. One cannot but wonder if other unsuspected health hazards exist.

State Law on Pollution

The law governing pollution was passed in 1920, and has been subsequently amended. It has certain loopholes, the more important of which are the exemption of some communities from its provisions—Newport, Jamestown and New Shoreham—and the fact that it cannot apply beyond the State borders. It is weak in that thirty days' notice is required before action against an offender can be begun. With these exceptions it is a very comprehensive law. If a boy cleans a chogsett on the rocks and throws the head in the Bay he has committed an illegal act. Enforcement is the function of the Sanitary Engineering Division of the Department of Health, whose duty it is to investigate any known or suspected violation, on its initiative or on complaint, to hold hearings, make findings of fact, enter corrective order, and to consult with and advise individuals, corporations or municipalities. Prosecution of persistent offenders is delegated by the Division to the Attorney General's office. The validity of the rulings of the Division has been established by the Supreme Court. Soon after

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For years the pollution of our waters has been getting increasingly worse. The situation is now so serious that it has become a menace to the public health; large areas of Narragansett Bay have had to be closed off from shell fishing; property values, bathing and recreational facilities along our shores are adversely affected. We can ill afford to tolerate this ugly condition any longer. A concerted effort must be made under the State's auspices to cope with the problem *now*.

Realizing the seriousness of the situation, shortly after I became Governor I directed the State Department of Health to make a detailed study and investigation of our entire pollution problem. This has been done and a complete report of existing conditions and suggested remedies is now available to us. I urge you to give it your best study and prompt attention. The welfare of our people demands that corrective action be taken in this matter without delay.

. . . the . . . recommendations contained in this report are practical and sound. They should be adopted. A sensible and workable plan has now been suggested. Further delay would be inexcusable and I therefore strongly urge prompt action.

GOVERNOR JOHN O. PASTORE, *in his Inaugural Message to the Rhode Island General Assembly, at its January Session, 1947.*

passage of the law, the Board of Purification of Waters, predecessor to the present Division, enacted regulations to prevent oil contamination. These rules were appealed by the oil companies and upheld. Oil is also under Federal statue, the Anti-Pollution Act of 1936, and a coast guard vessel is on duty in the Bay again, after absence during the war, to enforce this law. There have been several bad spills in the past few months, and the need for strict State and Federal supervision is evident. The accidental nature of this type of pollution does not excuse the offenders. Railroads and automobile drivers are not exempt from suit for damages resulting from accidents. It is fair to say that two of the oil companies whose plants are in the upper Bay are cooperating well and have installed equipment to lessen this hazard.

It would be interesting to know whether the State law as it applies to industrial and sanitary sewage could be enforced. In the published report of the Department of Health plan previously mentioned the Division of the Sanitary Engineering, the agency of enforcement, states that as to areas other than the Blackstone-Moshassuck district, "It is felt that with the exception of Mt. Hope Bay, the existing pollution law can be applied with satisfactory results." In Snow White and the Seven Dwarfs, our little friend Dopey did not talk. Nobody knew whether he could as he had never tried.

The present unpleasant situation is the result of non-enforcement of our laws plus pollution from sources not covered by these laws—from exempted districts within the State, and from without the State. Our laws need revision on these points, and probably on others as well. It is self-evident that the problem is more than Statewide. Close cooperation with our neighboring states is essential, but it is wrong to argue that Rhode Island cannot clean her waters unless other states cooperate with her, when little effort is made to initiate such action and cooperation. We have immediate tasks to undertake within the State. We have carried tolerance too far when we condone the action of communities that have shirked their responsibilities in Statewide antipollution efforts, and which continue to dispose of their sewage in a manner that is a continual menace to the health of other parts of the State, that makes our streams and waters unfit for any recreation, and that causes extensive property damage. The most conspicuous offender in this respect you all know—the City of Pawtucket. In 1929 Pawtucket was ordered to build a sewage disposal plant, after due hearings had been held and the city found guilty of pollution; but after eighteen years the plant is still unbuilt, and every day from 20 to 30 million gallons of untreated sewage is poured from the mains into the Blackstone and Seekonk Rivers, to empty into the Providence River and Narragansett Bay. Let our State clean up our share of the Blackstone River, and also cooperate to the fullest with Massachusetts toward the end of abating the pollution in their share. There is little incentive for the oil or other industries to strive for betterment of their waste disposal conditions when the governing body—the State—tolerates such flagrant violations.

Vital Points

If we look for reasons why our sanitary laws have had so little enforcement, we quickly come to some vital points. Personnel for enforcement is limited. The problem is large and complex, interlocking with other states, involving many industries of many kinds, all of theim important to greater or less degree to our economy. They provide the payrolls that are our largest financial resource. The magnitude of the problem and the real importance of possible violators, private corporations or civic communities, is one reason. Lack of sustained official interest is another and an important reason. All too often such interest has been displayed only around the first Monday in November. The main reason, however, comes from the deeper strata of our society, rather it does not so come. There has been insufficient arousing and maintaining of public interest in the problem. It affects us all. We are being deprived of our right to enjoy and benefit from Narragansett Bay and our waterways. They should be a means of health and recreation unsurpassed in any other state, a source of livelihood for many. We are forced to endure instead polluted waters, increasingly impossible for recreation, and definite menaces in many ways to our health. And there is no need for it. Other communities are learning how to adjust their industrial and sanitary problems so that their waters are again becoming health and recreational assets, instead of liabilities, without the sacrifice of industry. If we are to make progress toward that goal in Rhode Island, we must work for it. We are members of a profession that believes that diagnosis is essential for proper treatment. Diagnosis means study of the case, learning the facts involved. That is essential here. A comprehensive survey of the water potentials of the State, a similar survey of the present and possible future industrial and sanitary demands upon them, with planning to adapt our industry, present and future, to its basic water needs is required. It is necessary for communities as well as tailors to fashion their suits according to their material.

Similarly, a sanitary survey of the Bay to determine the present extent and degree of its polluted area is very desirable. The medical profession would be greatly pleased to find that pollution has

not extended beyond its known limits. If there has been any such extension, as has been stated in the committee report mentioned, appropriate measures to eliminate health hazards in our fisheries and recreational use should be taken. We feel that the citizens of this State have a right to know the present condition of their Bay.

The proposed Health Department plan seems excellent in many respects. We here are interested in the problem primarily from a health standpoint, and must depend on members of another profession, that of sanitary engineering, to determine the ability of any plan, if properly carried out, to produce and maintain necessary health standards. If on due study this plan promises to meet these requirements, it will have the whole hearted support of this and all other medical societies within the State and of all individual members of our profession as well.

Public Interest Important

Most important of all, in an attack on the problem, is the arousing of public interest to the point that enforcement of suitable laws is possible. No law is stronger than the public opinion that upholds it. There is no question that the laws regarding theft and murder are put in the statute books to be enforced. Our citizens have definite convictions on these questions, and their voice is strong for proper punishment of those guilty of these crimes. So far, however, they have not vigorously demanded the return of their rights to enjoyment of state waters, taken from them by pollution. In the twenty-six years since the anti-pollution law was enacted there have been many resolutions, surveys, meetings of protest, and promises concerning pollution abatement. To glance back over the recent record: in May, 1937, the Health Department closed 13 per cent of the area of Narragansett Bay to the taking of shellfish, because of pollution; in 1939 Governor Vanderbilt agreed that the Bay must be cleared up; in 1941 Governor McGrath and the State Planning Board objected to the pumping of sewage into the bay from the Navy's housing project at Middletown; Barrington citizens urged action on pollution and named Central Falls, Newport, Jamestown, Pawtucket, Middletown and Fall River as offenders. Governor McGrath said the State would cooperate in the drive to end bay pollution, and suggested a series of State-owned sewage treatment plants, and the Providence City Council condemned lax enforcement of present laws and also noted that "a lack of proper plans to eliminate pollution" constituted a health menace. In 1942, the Fall River City Council prepared to take action on Mount Hope Bay pollution, the Bristol County Lions Club continued its drive against pollution with 47 supporting organizations, a Newport pier was posted following the finding of raw sewage on the nearby shore. In 1943 the State Health Department closed South Cove, Wickford, to shellfishing and investigated the dumping of raw sewage there, the Bristol Town Council invited the Division of Sanitary Engineering to participate in an open meeting to start investigation of harbor pollution—an invitation that was declined.

There is no need of adding to this list. The coordination of these different organizations and others interested is desirable: the sportsmans' organizations, the fishermen and yachtsmen, all our public-minded groups might be so correlated that their efforts would be more united, and, therefore, more effective. It is beyond the scope of this talk to detail plans of procedure, but whatever plans are made and followed, whatever further changes are necessary in our laws, active public interest will be necessary for the support of our enforcement staff. If the citizens of this State, are sufficiently aroused to the importance to all of us of this condition, and let our appointed and elected officials know unmistakably of our interest, our wishes and our expectations, we will be taking sure steps toward the solution of the problem.

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PEDIATRIC PROBLEMS OF THE GENERAL PRACTITIONER*

HENRY E. UTTER, M.D.

The Author. *Henry E. Utter, M.D., of Providence. Member, Visiting Staff, Rhode Island Hospital.*

THE PROBLEMS of childhood which confront the physician are alike for both the man in general practice and the pediatrician. Subjects chosen for discussion tonight are those which lead to unhappiness and misunderstanding between physicians. These problems are simple but important. Children are taken from one doctor to another in the hope of finding a perfect solution of these matters. Persons take their children to another physician because of a lack of faith and to some extent intelligence. The layman too often believes that medicine is an exact science where as we realize that this is not true: he thinks a physician should be able to answer correctly all his questions relative to health and disease. Each physician may handle an individual problem in a different manner but the same result may be obtained.

I. Infant Feeding

Our methods of infant feeding have changed materially in the past twenty-five years. Our mode of life with its greater stress upon the nervous system, the entrance of the woman into the affairs of the world with the resultant demand upon her for out of the home activities and above all the universal trend toward the hospitalization of all women for the delivery of their infants are the main factors which are responsible for the changes in the system of infant feeding.

Formerly when babies were born in the home nearly all mothers nursed their infants for a varying length of time. There was a more intimate relation between the mother and child from the start of the infants life. The mother who suffered the pain of labor perhaps was more appreciative of her infant because of the difficulties of her labor. Today the mother has a painless labor, is divorced from her baby during its stay in the hospital and more than half of our women never nurse their babies. This raises the problem of artificial feeding from the first day of life. Many trial formulae are given and with each failure during the early weeks of adjustment to cow's milk the advice of a different physician is sought. This leads, even though unavoidable, to unhappiness among physicians.

If the baby is breast fed many of these early matters of maladjustment to cow's milk are eliminated. There are still physicians who believe that breast feeding is the correct and easy way to feed a baby and that bottle feeding is the wrong and hard way. There are obstetricians who believe that breast feeding hasten the convalescence of the mother and fosters a more stabile nervous system in the post partum months. There are surgeons who state that cancer of the breast in later life is more common in women who do not nurse their infants than in those who do even for only a short period. These surgeons believe that the high cholesterol content of the first milk which is left in the breast with dilatation of the ducts of the mamary gland is detrimental to the future health of the breast. On the other hand there are men interested in the cancer problem, from experiments on mice, who think that should there be a definite history of cancer in the family, that the mother should not nurse. This is a whole matter for discussion in itself.

In your care of feeding cases a friendly criticism of the man in general practice is that too much time is devoted to the matter of formulae and calories rather than to the general life of the infant. The questions relative to the schedule of feeding, the hours to be spent out of doors, the amount of fresh air to be allowed the baby at night, the clothing of the baby, the number of blankets to be placed over the infant at night and above all emphasis upon a minimum handling of the baby together with a psychological study of the mother herself are of infinitely greater importance than are the ingredients of the formula, which however, must not be neglected.

There is probably no type of case which comes more often before the pediatrician, with resultant ill feeling on the part of the general practitioner, than does the problem of infant feeding. What then should be the attitude of the pediatrician in the case of infant feeding which has been under the care of another physician? If the infant has been referred by a physician for advice there should be no question as to the disposal of the case. Advice should be given and the baby returned to the original physician.

* Presented before the Bristol County Medical Association, November 1946.

In all cases which have been under the care of other physicians the pediatrician should make an attempt to continue the formula given by the other physician or with as little modification as possible. An immediate change of formula destroys the faith of the mother in the first physician, a fact little appreciated by most physicians. To the mother a change of a radical nature of the ingredients of a formula indicates that the one she was using was wrongly constituted: often not the case. A change in the formula can be made later over the telephone if necessary without embarrassing another physician. Often the bill rendered by the first physician is never paid because the second doctor changed the formula, thereby convincing the parent that the first physician had made an error in the formula prescribed.

Another problem in ethics is presented to the pediatrician by the infant which he is called to see at a lying in hospital by the obstetrician. The mother may have been referred to the obstetrician for delivery by a physician who had no access to a lying in hospital service. The family doctor possibly expected to continue with the baby and is often dismayed to find that the infant has been referred to a pediatrician for feeding regulation. The pediatrician is ignorant of the situation and continues the care of the infant. At the end of the period of feeding supervision the pediatrician at least in the case of infants who come from a distant point should inquire the name of the home doctor and refer the child to him for future care.

Relative to the host of infants who have been under the previous care of one or more physicians the pediatrician has no alternative other than to accept the case. He must accept the prerogative of the mother in the choice of a physician. Many of these infants when the feeding difficulties have been rectified could be referred to the family doctor.

One of the most disagreeable matters for the pediatrician is to decide whether he should take care of a second baby which arrives two or three years after he has seen the first born in consultation. Perhaps the second baby was delivered by a different man and yet when the original doctor learns that the pediatrician is taking care of the second baby he resents the lack of faith which the family has in him. This situation is unavoidable for should the pediatrician attempt to refer the mother back to the original doctor she will usually flatly refuse. Later, however, when the baby has improved and her apprehension has been allayed the family doctor might assume the care of the child.

II. The Annual Physical Examination

At first thought you might ask—why mention such a protean subject? The lay press, the Federal Child Health Bureau, insurance companies and our medical journals advise this and it has become in the minds of many mothers a necessary annual function. Many children brought to the pediatrician have during the year been under the care of the family doctor. Why then should the mother take the child to the pediatrician? Does she believe that he will give a more thorough examination? If this is the reason, it should not be true.

The annual examination should consist of an examination of all organs. The child should be weighed and measured. Especial attention should be given the teeth and feet of growing children. The urine should be tested. A patch tuberculin test should be done; if positive an X-ray of the chest should be taken. The physician should acquaint himself with the quality of the family milk supply. He should inquire about the diet and make sure that all food elements are being given. All children should have vitamin D preferably in the form of pure cod liver oil. All other vitamins should be provided in the food.

The parent should be discouraged in the use of multiple vitamins, important to the pharmaceutical house perchance but having no place in the diet of the properly fed child. The parent who gives her child multiple vitamins tries to relieve her conscience for not providing the proper food. If an added vitiman is indicated use that vitamin and not a shot gun mixture of vitamins.

If the general practitioner will give a full physical examination to each child coming to him for this purpose rather than passing over the matter lightly the pediatrician will not be so frequently consulted for this reason.

III. The Tonsil Question

This is primarily although not entirely a problem of childhood. Some years ago tonsillectomy was considered an element of preventive medicine but ideas have changed in this matter. The tonsil is not a vestigial organ in the process of evolution. Tonsil tissue is a part of the lymphatic or if you will the filter system of the body. The tonsil of the child is digesting the bacteria which gain access to the throat. In the fall of the year when respiratory disease becomes more prevalent routine examination of the throat will often reveal large, red and swollen tonsils when the child has no outward manifestation of illness. Not infrequently when a child loses its appetite with no other symptoms we find a swollen, inflammed tonsil. Only when a child comes in contact with an overwhelming number of bacteria does the child become ill. Is this illness any more than a manifestation on the part of the

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body calling upon other defensive measures such as a temperature and an increase in the leucocytes?

One attack or more of simple uncomplicated tonsillitis do not form a positive indication for tonsillectomy if the tonsil quickly returns to normal. The physician who condemns the tonsil to operation during an acute attack opens himself to criticism by the family. The parent of such a child will probably take the child to the nose and throat specialist or the pediatrician who finds a small innocent tonsil which has returned to normal. The physician should see the child after the attack and reserve his decision about the removal until then. The physician who hears a cardiac murmur while the child is ill and reveals his discovery to the parent likewise opens himself to criticism of the family. The persistence of the murmur after the subsidence of the fever should prompt the physician to tell the parent. Many of these children fall into the hands of the pediatrician for confirmation and he finds no murmur after the attack of fever.

Tonsillectomy should be postponed until the child has passed the age of four if possible and the later the operative date the more permanent the result. 1. Removal of the tonsil of young children is nearly always followed by lymphoid hyperplasia in the pharynx and tonsillar fossae. 2. This lymphoid tissue becomes easily infected and is responsible in a large measure for the intractable night coughs which are so disturbing to parents. 3. Early tonsillectomy in the allergic child is often followed by attacks of asthma, usually in the child precipitated by an acute upper respiratory infection. 4. Children whose tonsils have been removed are more susceptible to sinusitis and bronchitis. The tonsil having been removed the mucous membrane of the sinuses and the bronchi become much more vulnerable to attack. 5. Deafness is more common in the child whose adenoid has been removed. This may be due to the fact that new lymphoid tissue encroaches upon the orifice of the Eustachian tube. Occasionally too vigorous use of the adenoid curette may destroy the mucous membrane at the tubal orifice.

What then are the positive indications for the removal of the tonsils? 1. Rheumatic fever or one of its manifestations. I have always believed and have had no occasion to change my mind that the virus or whatever the infecting agent may be always enters the body through the tonsil or lymphoid tissue which appears after tonsillectomy. 2. Repeated attacks of tonsillitis complicated by cervical adenitis or otitis and when the tonsil does not return to normal after an attack. 3. Deafness as the result of a chronically inflammed adenoid. 4. Tuberculous cervical adenitis. 5. Given a child who is below par and in whom there is a negative physical examination, urine blood count and tuberculin test; tonsillectomy in such a child will usually be followed by a return to normal health.

IV. Respiratory Disease

The treatment of respiratory disease in childhood has undergone radical changes with the advent of the sulfa drugs and penicillin. Complications have been greatly reduced and many lives are being saved which might have been sacrificed before these drugs were available. Next to the feeding case the child with recurrent or chronic respiratory disease is more commonly taken from one doctor to another. A cough, particularly a continuous cough or the night cough which disturbs the sleep of the whole family is an ominous sign in the minds of the layman. Cough mixtures so commonly prescribed as the only treatment are of little value. The site of the infection must be determined and treated accordingly.

Studies in allergy have produced much interesting information pertinent to respiratory disease. The allergic child is much more susceptible to infection than the non-allergic child. We are convinced that the child or adult who is susceptible to respiratory disease is also a subject of allergy. Children who have chronic sinusitis are for the most part allergic individuals. Thus in a large group of children allergy tests must be done to determine the underlying factors in the production of bronchitis other than a simple acute attack and sinus infections. Scratch tests are simple and in the majority of cases only the more common allergens need be used. If we will devote our attention to the treatment of the site of infection, we will have a less frequent change of physicians.

What of the use of the sulfa drugs in acute respiratory disease? There still exists in the mind of many physicians a fear of the sulfa drugs. This fear is based on the fact that we are taught in using these drugs to raise the blood level to 10 m.g. per cent. This means that we prescribe the maximum dose when often this is not necessary. If we would use the sulfonamides in proportion to the severity of the symptoms, we would have better results and few reactions. Children tolerate the drugs better than do adults. If we start the drugs at the onset of an acute infection we will have a minimum of complications. We may encounter a simple catarrhal otitis or cervical adenitis but seldom will either go on to suppuration as in the presulfa days. In severe respiratory disease both the sulfa drugs and penicillin should be prescribed conjointly.

V. Loss of Appetite in Normal Children

This is a common symptom because of which parents change their physician. This is a common problem for the pediatrician. It is a problem of the pre-school years and later. The child refuses to

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PODOPHYLLIN IN THE TREATMENT OF CUTANEOUS VEGETATIONS

F. RONCHESE, M.D.

The Author. *Francesco Ronchese, M.D., of Providence. Dermatologist-in-Chief, Rhode Island Hospital; Instructor in Dermatology, Boston University.*

PODOPHYLLIN, no more in official use as a cathartic, has been returned to service in the therapy of acuminated warts (condylomata acuminata, soft warts), the cock-comb-like, cauliflower-like vegetations growing in the warmth and moisture of genital and anal areas. Acuminated warts are often called, improperly, venereal warts or venereal vegetations, because they are not necessarily related to a venereal infection.

Sometimes the areas involved are so extensive and the warts so voluminous as to offer a serious therapeutic problem.

Apparently, the same penetrating-irritating power of podophyllin for the intestinal mucous membranes causing catharsis, penetrates and shrinks the polipoid vegetations growing on the mucous membranes of the penis, vulva and anus. It seems to be completely ineffective on the hard (vulgar) warts of various types developing on the skin.

I have experienced several times in cases of acuminated warts of the glans penis and foreskin, that the efficacy of podophyllin stops abruptly at the line of transition between the semi-membrane and the skin proper. When the acuminated wart becomes a hard (vulgar) wart no more penetration of podophyllin takes place.

Kaplan[1] was the first to use the remedy as a mixture of 25 per cent podophyllin in mineral oil and others[2] confirmed the results and contributed to the subject with experimental studies.

In my experience the method is very effective and saves a great deal of time and distress, specially in the female, avoiding hospitalization, anaesthesia and surgical procedures.

The method is not as good in the male because of the possible balanitis. If the foreskin is present and many warts are to be destroyed, circumcision is preferable.

While spontaneous overnight involution of vulgar warts is a matter of common knowledge, I have found in the literature only one case of spontaneous disappearance of acuminated warts. Gaté and Coste[3] tell of a 4 months pregnant woman with vulvar vegetation so exhuberant that she was prepared for surgical excision. Because of a stomach ailment she was given by mouth a mixture of bismuth, magnesium, sodium bicarbonate, calcium, kaolin. Four days after, the vegetations became smaller and in 29 days they had disappeared completely.



Acuminated condylomata of vulva (A), male urinary meatus (B), anus (C), suitable for podophyllin therapy. Acuminated condylomata of foreskin (D) too hard for podophyllin therapy.

Would podophyllin act through the same inexplicable channels called suggestion?

Object of this paper is the report of the following case:

"A middle age man, a polisher in an optical factory, had for several weeks a patch of sycosis vulgaris on his chin. This condition showed the usual resistance to various forms of therapy (penicillin, furacin, tyrothricin, quinolor,

continued on next page

roentgen rays, etc.) One day, after removing a heavy coat of dried up exudate holding on a frame work of heavy whiskers, the area appeared papillomatous, and bleeding freely from long digitated papillae, having the clinical appearance of the acuminated condylomata seen in the male or female genitalia (see illustration). Evidently, the solid shelter furnished by the heavy whiskers and the dried up exudate duplicated the situation promoting the formation of acuminated condylomata about the genitalia, namely, a warm, enclosed area soaked in a muco-purulent exudate.

After clipping a few vegetations for pathological examination, I applied, as I have done for acuminated condylomata, a thick layer of a 25 per cent mixture of podophyllin (Resin Podophyllum, N.F.) in a water soluble base (Hydrosorb). The patient was instructed to keep the dressing on for 8 hours and then carefully cleanse the area with mineral oil and apply boric acid ointment.

The local reaction was severe. The man had to stay home for one week with wet dressings and sedatives, but at the end of the week his chin was perfectly clear of vegetations and of his sycosis. There were no signs of recurrence after several months."

Garnier, discussing Touraine communication[4] recalled the excellent results obtained in the past with the use of sabina powder in acuminated warts. Perhaps the old formula (Sabina U.S.P. powder-alum powder-copper sulphate powder — equal parts) could be also revived, and eventually studied as has been colchicine[2].



Acuminated condylomata-like vegetations on a man's chin following a long-standing sycosis vulgaris.

Summary

A case is reported of cutaneous vegetations occurring on a man's chin after a long standing sycosis barbae.

The vegetations had the clinical and pathological features of acuminated condylomata. Genital contamination could be reasonably excluded.

As various therapeutic methods failed, a 25 per cent podophyllin ointment was used with success.

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OTOSCLEROSIS, PROGRESSIVE DEAFNESS AND CORRELATED PROBLEMS*

What Has Research Discovered and What Does the Future Promise?

EDMUND PRINCE FOWLER, M.D.

The Author. *Edmund Prince Fowler, M.D., of New York City. President, New York League for the Hard of Hearing.*

FROM THE SUBJECT assigned to me, it is obvious that you did not expect much that is new, and therefore would not be disappointed if I were to repeat the usual statement that, whereas nothing has been discovered regarding the cause of otosclerosis nor regarding its cure, we must still continue our research.

To say this would lead to false implications. We do know a great deal about otosclerosis and about the changes in the tissues of the ear which we call the lesion of otosclerosis. We have discovered that these changes occur in every year of life, and even before birth, although they seldom cause deafness early in life.

In spite of the fact that a knowledge of the morphology, that is, the microscopic appearance of otosclerotic changes, has not given us any clue as to cause, it is nevertheless fundamental, and aids in setting up theories. If we did not known what changes take place we would be unable to recognize the lesion when we see it. The appearance of the otosclerosis growth is now so well understood that it can be differentiated from other diseases of the bone with which it was formerly confused.

Whereas our knowledge in morphology and pathology is now complete, the factors concerned with the predisposing and exciting causes of otosclerosis are still nebulus. The only sure factor is heredity, but heredity, alone, is not the cause of otosclerosis. As for symptoms, probably the majority of my audience know them better than the doctors.

Central Bureau of Research

Only a few of the important discoveries can be mentioned here. To insure continuity in research a worker must have security and encouragement for long time effort, and this can come only through continued financial and inspirational support. Such has been the basic policy of the Central Bureau of Research of the American Otological Society. For twenty years this Bureau has aided many men and many institutions in their studies to find out how the ear works in health and in disease. When published, a copy of their report, including the latest developments in otosclerosis and correlated fields, will be sent to each Chapter of the *American Hearing Society*.

Diagnosis

Early diagnosis is a prerequisite to satisfactory treatment. Early diagnosis implies a perfection of tests and testing. It depends largely upon hearing tests and careful otological examination, at the very latest when the child enters school, and earlier in otosclerotic families. Slowly, but surely, differential diagnostic criteria are being perfected. We have discovered tests for surely differentiating nerve from obstructive deafness. But there are many types of obstructive deafness.

The greatest difficulty has been to differentiate deafness due to bony ankylosis from deafness caused by fibrous adhesions. Many cases of fibrous obstruction have been mistaken for otosclerosis. If we cannot make a sure diagnosis in a high percentage of cases we cannot obtain reliable statistics on the effects of treatment. To my mind these facts clarify the picture and encourage factual thinking.

Incidence

A large number of you have been told that you have otosclerosis; a very large number of people have otosclerosis and do not know it. In fact, nobody knows it until it causes deafness, and a diagnosis is made.

In the United States it is estimated that there are between 10,000,000 and 12,000,000 people with otosclerosis. Of these, between 1,000,000 and 1,200,000 have an ankylosis of the stapes sufficient to cause deafness. The immensity of the problem is apparent.

The incidence of otosclerosis varies between races, and with age and sex. In the white race it is encountered about twice as often in women as in men. In those under twenty-one years of age this sex ratio is higher. The activity of otosclerosis, in other words, its growth and extension, and therefore its increasing threat to hearing, varies greatly

continued on next page

* Presented at the Eastern Zone Conference of the American Hearing Society, at Providence, R. I., October 24-26, 1946.

with the age of the individual. Only 4 per cent of those over five years of age, autopsied by Stacy Guild, showed otosclerosis, but if the Guild's survey had contained the same number of females as males, the figure would have been much higher.

In the Negro the percentage of occurrence is different; almost unbelievably different, because the incident figure for the Negro is only about 1 per cent. The question naturally arises:

Why does the white race have otosclerosis so much more frequently than the Negro?

We welcome suggestions on this subject. Between the two races no significant differences in the blood or the tissues have been found which cannot be explained by variations in environment, particularly climate and diet. However, it may be worth noting that the Negro mother regularly nurses her baby, the white mother not half as regularly. There are certain differences in the chemical content of the milk of the two races. There are, of course, several marked differences between human milk and cow's milk, and, for the human infant, all are in favor of mother's milk.

All of these factors may, and often do, influence the development and aging of the bony tissues and the functioning of the endocrine system; and more so at certain ages. These facts appear to be important discoveries. There are many others.

Ankylosis

The mere presence of otosclerosis is not the important thing. The important thing is the activity of the lesion and the rate and extent of its growth. Unless it reaches a size sufficient to involve the membrane between the stapes and the oval window margin, otosclerosis is not disabling; nor does it cause deafness. It is the ankylosis that causes the deafness, and otoclerosis usually does not cause ankylosis unless it is active for a long time.

It is encouraging to have discovered that in people found at autopsy to have had otosclerosis, only one-half showed active lesions. In other words, in only half of the people who had otosclerosis over a period of years prior to their death was it progressing at the time of death. To those about to die, this is of no great importance. But to those who expect to live for many years it is a comforting thought. In only 10 per cent of those with otosclerosis was there any deafness which could be attributed to otosclerosis. Coincidental middle ear or nerve conditions, having little, if anything, to do with otosclerosis, accounted for a history of deafness in 90 per cent of the ears harboring otosclerosis.

Still more encouraging is the fact that in those autopsied by Stacy Guild, after the age of fifty, only one in three showed active lesions. That is, only one out of three persons over fifty years of age, having otosclerosis, was at the time of his death threatened by any deafness, or by any increasing deafness resulting from otosclerosis.

Other causes of deafness, of course, begin to operate more frequently in people over fifty, so that if it isn't one thing, it is another. However, before fifty years of age we can, in fairness, expect only a 50-50 chance in most things; after fifty, a 2-1 chance is perhaps more than we should expect.

Again, I want to stress the importance of early diagnosis. It is true that the hearing loss in otosclerosis tends to progress slowly to about a 50 per cent loss for speech, and thereafter to become stabilized unless other troubles supervene. Because the otologist seldom sees a patient suffering from otosclerosis before severe damage has been done, he has no opportunity to try out certain remedies which would seem indicated to arrest the disease and the accompanying progressive deafness.

Operation

Although it seems inconceivable that the bony changes which cause deafness in otosclerosis can be removed, it is conceivable that they may be stopped. Certainly in many instances they can not only be stopped, but, in part, may be circumvented by operation. I say "circumvented," not "removed," because the fistula operation, in spite of many assertions to the contrary, gives no evidence of having any curative effect upon the otosclerosis, nor does it prevent its extension. Moreover, it cannot restore the hearing. It can, and often does improve the hearing, and in many instances to a considerable degree. The operation is still experimental, but in proper hands, in favorable cases, shows promise of giving relief for variable lengths of time.

We have discovered some of the reasons why the operation so often fails, and this knowledge has been applied to operative technique. Much progress has been made, but even now, we cannot in truth assure any patient, no matter how favorable a subject, that his hearing will be restored, or improved to any given degree. He must take his chance, which, even if the patient belongs in the favorable class, is only 50-50 for a result satisfactory enough to warrant the expense and risks involved. To some people, even a slight improvement appears to be satisfactory, but the operation is seldom warranted if we obtain only a slight improvement in hearing. To much is involved for too little.

I am aware that some statistics show a remarkably high percentage of successes in what are called favorable cases. The difficulty is that the surgeon is unable often to determine beforehand which is, and which is not, a favorable case. If he chooses the favorable case after the operation, he is picking the winner after the race is won. I say this to cau-

tion you against accepting statistics without examining the methods of their compilation, without knowing their reliability, and without realizing the many variables underlying all surgical procedure.

Much time and effort have been devoted to discovering a method of preventing the closing of a fistula by the regeneration of bone following fenestration operations on the monkey. J. B. Lindsay, at the University of Chicago, found that the closing of the fistula arose from regeneration of the periosteal and endoesteal (inner and outer) layers of the capsule. Also, that the endosteum cannot be left without leaving some bone flakes, thus forming a network for bony degeneration; and that complete removal of the bony fragments always resulted in the removal of the endosteum. Many kinds of fistula covers or "stoppers" were used in many locations, and with many variations in technique. It was found difficult to remove the bone fragments completely without injuring the membraneous canal and the endosteum beyond the margin of the fistula. No certain procedure was found to permanently maintain patency of the operative fistula.

Hearing Aids

During the past twenty years there has been a great improvement in hearing aids, so that those with even severe deafness from otosclerosis can be made to hear quite well at conversational distances. If properly made and adjusted, a hearing aid is able to increase the loudness of any sound more than the fistula operation.

A new phenomenon in the physiology of hearing was discovered. I call it the "recruitment phenomenon," or "recruitment of loudness phenomenon." Recruitment is present in all cases of nerve deafness; it is never caused by obstructive deafness. Those with nerve deafness often have difficulty in using hearing aids because there is an abnormal increase in the loudness of sounds when their intensity is increased. Some day, I predict, we can hold this recruitment effect down to comfortable levels. What is needed is an acoustic shock absorber which will permit a sound to reach the ear up to a given desired intensity, and no further. Hearing aid manufacturers, please take notice.

Contributions to Research

Research has contributed much to our knowledge of how the ear works. For many years, Doctors Wilson, Anson and Bast have been studying the developmental changes and mechanics of the ear in health and disease. They have found in the human ear an interesting connective tissue cleft which extends through the bony otic capsule just in front of the oval window, and this so-called fissula (not fistula) sometimes is involved in developmental defects affecting the cartilage and bone surrounding it.

The region where this fissula exists is the place of predilection of otosclerotic foci. There is here, therefore, an embryological basis for abnormal tissue which may be implicated in the changes causing otosclerosis. Many intra labyrinthine structures were carefully examined at various stages of their life cycle, and several new structures described.

The size of the stapes was found to vary considerably at all ages, and sometimes as much as one and one-half times. Its structure also varies with advancing age. The stapes grows so rapidly that it reaches full adult size by the time the fetus has completed the first half of its intra uterine life. Other human bones generally do not obtain full size until the individual is eighteen to twenty years of age. From the fifth to the seventh month of intra uterine life the stapes also attains adult form and consistency. So you see, this, the tiniest bone in the body, like the bone immediately surrounding it, is fully grown and therefore quite old at birth.

Experiments with Animals

In the brilliant experimentation at McGill University the hearing of animals was studied by the method of the conditioned reflex. It was found that the human being could not hear the higher pitches as well as many lower animals. The dog proved to have better pitch discrimination than the cat, but more difficulty and diffidence than the cat in learning to raise the lid of the food bin. The dog was more easily distracted than the cat. In pitch discrimination, man is superior to both. (This may be the reason why man, in spite of his post war tribulations, is still in there pitching!)

Dworkins' animals with partial deafness due to localized lesions in the cochlea were sent to Davis and Lurie at Harvard Medical School for correlative studies with electrical stimuli. It was substantiated that the inner ear acts as a transformer of acoustic into electrical energy, and this microphonic action was used as a tool for analyzing the effects of contractions of the inner ear muscles upon the transmission of sound.

No experimentor has been able with certainty to produce otosclerosis in animals, although lesions similar to otosclerosis have been produced by various operative and chemical procedures. Injuries, acoustic shocks, and temporary fatigue produced by intense sounds, have received especial attention. A most significant contribution to research has been the isolation and analysis of the electrical activity of single nerve fibers in the auditory nerve. For a discussion of these I refer you to the progress report of the Central Bureau of Research.

continued on next page

The animal hearing laboratory at the University of Illinois came into existence by a grant from the Central Bureau of Research. Here, and at the University of Rochester, Culler trained (conditioned) animals to respond by simple movements to any audible tone to which they reacted as long as they heard it; that is, as long as the tone was not below the threshold of hearing. When the sound was inaudible they no longer reacted. In this way it was possible to have the animal, both before and after the different operative procedures, signal when he heard the test sound.

With electrical methods the problems could be attacked in several ways. It was concluded that:

(1) Each frequency has its own focus of response within the cochlea, this point being revealed by the electric potential therein generated.

(2) The location of this focal point can be fixed within standard error of 5 per cent.

Extensive experments with electronic potentials from the cochlea and from the auditory nerve and tracts show that these potentials differ. These from the cochlea arise in the ear itself as they can be obtained even after the nerve has been cut, and the endorgan of hearing destroyed; and sometimes, even after death. Each discovery leads us one step further along the path of knowledge.

The relative value of the auditory tracts to the brain were studied. It was found among other things that there appeared to be no appreciable difference in the hearing after removal of the right or the left hemicortex.

The effects from removing various other portions of the brain and cochlea were studied. All of these experiments showed a high safety factor in the hearing system; so high, in fact, that it compares very favorably with that found in engineering practice. These experiments brought out many facts fundamental for an understanding of the healthy and diseased mechanism of the ear.

It has been claimed by some that X-raying of the petuitary body in the skull improves the hearing. Culler's experiments show that this may be true in many instances, but the effect is always transient. It should be noted, in passing, that repeated X-raying of the head of a human being may be dangerous.

Culler mapped the distribution of the auditory nerve in the central ganglia and in the auditory cortex, and its frequency distribution in the cortex of the cat. There seems now to be little doubt that frequency localization begins in the cochlea, and persists throughout the auditory tracts to the cortex. Culler also examined the hearing of dogs before and after taking certain selective nerve poisons.

These researches provide a lead for defining the mechanism by which auditory nerve impulses are routed through the cortex of the brain after they reach the temporal projection area.

It was held in the past that partial section of the auditory nerve had no appreciable effect upon the hearing, but it has been found that even a slight destruction causes some impairment. Extensive cutting of the nerve causes a large impairment of hearing. A differential character to the losses is detailed in the progress report to which I have referred.

Studies on the higher acoustic mechanism in the cat were carried out by training these animals to react whenever the intensity of a testing tone was suddenly increased. The minimum detectable increase was determined. The usual test determines when a tone is barely audible.

After complete removal of the auditory cortex on both sides of the head, these animals, when retrained, showed post-operative (minimum differential) thresholds the same as before operation. In other words, in the absence of the auditory cortex on both sides, subcortical centers were just as efficient in differentiating the loudness of two tones as was the cortex area itself. Moreover, the discrimination habit remained intact, and differential thresholds were not significantly altered after destruction of the inferior or superior colliculi on both sides.

Many similar experiments were carried out. Studies on the peripheral mechanism of hearing, and especially on the nature of masking, revealed important and hitherto unknown facts.

Other Studies

Thousands of temporal bones have been collected, serially sectioned, studied, and carefully filed for future use. Models of both the bony and membraneous labyrinths have been made. Systematic examination of all patients have been made by one of us (Fowler) and recorded under six diagnostic and several age groupings. Careful otological examinations with blood chemistry, X-rays, endocrine and metabolism tests, have revealed some interesting facts. It is now believed that the most promising approach to the problem of otosclerosis and other forms of porgressive deafness lies in clinical research.

Changes in the hearing at puberty, during menstruation, and pregnancy; the puerperium, lactation, and the menopause were studied. There is apparently no difference in changes in hearing during menstruation in those with otosclerosis and those with deafness caused by other obstructive lesions. The hearing always returns eventually to its former level.

Studies, also, were made of people with brittle bones, blue scleras and otosclerosis. Means have been devised for measuring the loudness of tinnitus

and detecting its place of origin and its implications in diagnosis.

Call for Twins

Studies in identical twins have revealed many interesting identical and differing reactions to environment. In five pairs, one twin in each pair is being treated differently from the other. We need more identical twins. That is a strange call from a man, but I mean it. Please remember to send me more twins, especially twins with a family history of otosclerosis. Also wanted are triplets, quadruplets, and even quintuplets.

And here is my final word. Please, please send these children early, before crippling deafness appears. If you will do this not only for your twins, but for all of your children, the future promises much in the prevention and arrest of deafness.

PEDIATRIC PROBLEMS OF THE GENERAL PRACTITIONER

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eat without the coercion of all members of the family. At each meal there appears the enactment of a drama with the child acting the part of the hero.

The main cause of this condition lies in the fact that during the first year of life the average child eats more food than during the second and third years of life. This is due to demand on the part of the body during the first year of rapid growth. The average mother thinks the child should eat more with advancing age. This starts the forcing procedure and then follows the pattern of feeding which seems quite normal to the child. Teething or an illness in the second year may be responsible for the anourexia because the child is forced during an illness and the pattern persists after the tooth has erupted or the illness has passed.

Tonics have little effect. Leaving the child to dawdle over its food does not change the type of eating habit. The parent is never satisfied to be told that the child will eat when it is hungry. Limiting the amount of time spent at the table does not suffice. The secret in brief, consists in underfeeding the child. Small quantities of definite types of food should be prescribed. The child is the only one who knows the extent of its own appetite. The amounts of food should be increased only when the child requests an increase. The child must be taught to ask for food and only when this has been achieved will the eating behaviour pattern be changed.

In conclusion the most common problems of childhood which disturb the physician-patient relationship have been discussed. The relation between the general practitioner and the pediatrician should be a pleasant one and mutual helpfulness can result. If we as physicians would but appreciate the complete lack of ethics among the laiety we could better understand each other. Doctors are often misquoted in their remarks concerning each other. Often derogatory remarks about a physician are the products of a mind of an individual who enjoys the unhappiness which is produced by such language. Physicians would be much more contented if they omitted the criticisms so often heard, of their fellow practitioners.

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OUR SURGICAL PLAN

An Historical Report of Its Development

AT THE CALL of the president of the Society a special meeting of the House of Delegates was held on Sunday, December 17, 1944, to hear the report of the Committee on Medical Economics regarding a possible plan for prepayment of surgical expenses.

The report of the Committee was accepted, and its proposal that a committee of 11 members be formed to study the formation of such a program was adopted. Six of the members were to be members of the Rhode Island Medical Society elected by the House of Delegates for staggered terms, and these elected members were to elect five non-medical members to serve with them.

Prior to the first meeting of the entire group of eleven men named to serve on the committee, it was suggested by Mr. George Davis, one of the five citizens elected to serve on this volunteer committee, that enabling legislation should be introduced in the Rhode Island General Assembly before the 42d day. On March 10 the executive secretary furnished Mr. Davis with copies of the enabling acts for the incorporation of non-profit medical service corporations already enacted in other states. Mr. Davis drafted legislation over that weekend, and it was introduced in the House of Representatives of the Rhode Island General Assembly on Tuesday, March 13, 1945, and subsequently referred to the Committee on Corporations.

The first meeting of the entire committee was held on Wednesday, April 11, 1945. The non-medical members elected to the committee were Mr. Roderick Pirnie, Mr. George C. Davis, Mr. Ralph Kenyon, Mr. Charles Baker, and Mr. Harold Amrhein. At this meeting Mr. Farrell discussed the enabling legislation that had been introduced and particularly pointed out that Section 9 had been reviewed by the Committee on Public Laws of the Rhode Island Medical Society which had recommended that this section be amended to provide that the Society might authorize any non-profit hospital service corporation to amend its articles to adopt the provisions of this act (the surgical plan act) *in whole or in part.* As the act was originally written it made it mandatory to transfer to the Blue Cross Corporation *all* authority. The committee moved to approve of this amendment.

However, in spite of the opinion of the Society through its Committee on Public Laws and the official notification of its action to the Assembly committee and to the Governor and other authorities in the State government, the original legislation was passed as written.

At no time did any official of the Rhode Island Medical Society certify to any member of the Assembly or any other citizens that osteopathic physicians would be eligible for participation under the program.

* * * * *

A sub-committee of the special surgical study committee was appointed to study the question of relations with the Blue Cross Organization. This sub-committee comprised Mr. Roderick Pirnie, Mr. George C. Davis, Mr. Charles H. Baker. It made its report on October 24, 1945, in which it reviewed the actions of the previous meetings of the entire committee and made definite recommendations. A significant viewpoint was voiced in the following conclusions of the sub-committee report.

"After a most thorough consideration of all aspects of the matter it is our recommendation that the Rhode Island plan be patterned upon that of Delaware, which follows in general the pattern of commercial insurance with which the public is already familiar, but which has the added advantage of the endorsement and support of the medical profession. In this way, if the Blue Cross can be persuaded to undertake the project, a practical operating arrangement can be achieved so that voluntary medical protection can be made available to the public of Rhode Island, both for their benefit and also as a defense to the various compulsory programs. Under such a plan service would be rendered upon a fee schedule, payable either directly to the attending physician or to the patient as seemed desirable upon further study.

"While it would be of the greatest importance that a substantial majority of the profession give their wholehearted support to the plan, it should not be necessary that every physician be a member in order to provide service to its subscribers. Free choice of physician and patient would be retained. Financial stability would be insured if a substantial majority of the members of the profession in Rhode Island were to become members and, as such, undertake to provide the necessary services regardless of the financial status of the corporation. The experience of other plans makes it highly improbable that there would ever be need to fall back upon this protection, but if it exists the necessity is avoided of raising substantial funds to guarantee performance.

"Since indemnity rather than service would be the basis of the plan, there is no more likelihood that there would be any conflict of interests between the members of the profession, the adminisrative group and the patients than there is now with commercial insurance companies. However, in order to assure the member physicians that the rights would be protected, an impartial board of arbitration should be provided with full authority to settle any disputes."

At a meeting of the Surgical Insurance Study Committee on October 24, the sub-committee report, quoted in part above, was accepted and the committee moved that the recommendations be submitted to the Rhode Island Medical Society.

* * * * *

A special meeting of the House of Delegates was held on November 15, 1945 and the House voted unanimously as desiring a voluntary medical care program operated on a prepayment basis.

The House also voted to go on record as favoring a voluntary medical program which would be related to the Hospital Service Corporation with each service having a separate corporation and a separate board of directors, but a single executive director with one administrative staff. The motion was seconded and adopted.

A motion was made that the medical members of the surgical committee be asked to confer with the Hospital Service Corporation relative to cooperation with the Medical Society in the development of a surgical insurance program. This motion was adopted.

* * * * *

Special Meeting of the House of Delegates December 30, 1945

A special meeting of the House of Delegates was held on December 30 to discuss the question of Blue Cross participation in the medical-surgical plan of Rhode Island. At that meeting of the House Dr. Pitts reported that he and members of his committee had met with members of the Blue Cross to discuss the proposal. He stated that the House had been called to consider whether it would accept the Blue Cross's ultimatum that it was not willing to work with two separate corporations, one for hospitalization and one for medical service. The Blue Cross objection was based on the fact that it would entail additional work for the director and, further, the Blue Cross Corporation was not anxious to take on the work, but was willing to cooperate as a public service.

After lengthy discussion of the situation the House adopted the following motion:

"That the Rhode Island Medical Society accept the proposal of the Hospital Service Corporation

continued on next page

to cooperate with the Society in the sponsoring of a surgical-medical plan to be offered in Rhode Island in connection with the already existing hospital plan, provided that agreements are made that not less than 25 per cent of the Board of Directors of the Hospital Service Corporation will at all times be doctors of medicine appointed by the Rhode Island Medical Society for staggered terms, and further provided, that all medical and surgical fee schedules shall be adopted and amended only after approval by the House of Delegates of the Rhode Island Medical Society."

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House of Delegates Meeting—January 31, 1946

At the regular meeting of the House on January 31, 1946, Dr. Martin reported for the Committee relative to its meeting with the Blue Cross authorities. Highlights of his report, as well as the actions taken by the House of Delegates, were as follows:

He reported that the Committee favored a straight cash indemnity, but the arguments against this type of plan were strong. The program is to be one of community service to assist the lower income groups. But a cash indemnity only parallels existing private insurance plans. The Blue Cross membership has been built high by enrollment of the lower income groups, and to gain such groups for the surgical plan an income limit appears advisable. The Committee recommends, therefore, income limits of $2,500 for the individual, and $3,000 for the family.

Dr. Martin stated that the president and secretary of the Society would have to file an affidavit with the Secretary-of-State to authorize the Blue Cross to administer the surgical plan. He read as a suggested affidavit one that had been prepared by Mr. Davis, legal counsel for the Blue Cross, which read as follows:

"RESOLVED: That the Rhode Island Medical Society does hereby give its consent that the Hospital Service Corporation of Rhode Island, a non-profit hospital service corporation organized pursuant to the provisions of Chapter 719 of the Public Laws of Rhode Island 1939, may amend its Articles of Association to adopt the provisions of Chapter 1598 of the Public Laws of Rhode Island 1945 entitled "An Act Providing for the Incororation of Non-profit Medical Service Corporations and Defining Their Powers," to the end that the said Hospital Service Corporation of Rhode Island may have and exercise all of the powers and be subject to all of the duties and responsibilities of a non-profit medical service corporation to the same extent as though it had been incorporated pursuant to said Chapter 1598."

Dr. Mara moved that the Council of the Society submit a ballot with twelve nominees, and also provide suitable space for the writing in of counter-nominations, and that such a ballot be submitted to each member of the House of Delegates by mail for the election of representatives to serve on the Board of Directors of the Blue Cross with the six nominees receiving the highest votes to be declared elected; he further moved that the terms of office for the elected delegates shall be set by the House of Delegates at a future meeting. The motion was seconded and passed.

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Special Meeting of the House of Delegates February 24, 1946

At a special meeting of the House of Delegates on February 24, 1946, the proposals for the surgical plan were discussed anew. Legal counsel for the Society reported as follows relative to the enabling act:

It is our opinion, therefore, that the courts should, and probably would, limit the words "duly licensed" in the Enabling Act to those who have received a certificate to practice "medicine and surgery." This would exclude osteopaths and chiropractors who receive certificate to practice osteopathy or chiropractics.

The conclusions advanced by the legal firm were discussed by members of the House, after which the following motion was made:

The House of Delegates of the Rhode Island Medical Society instructs its elected representatives on the Board of the Hospital Service Corporation to request that Corporation to amend its by-laws to provide that only physicians having a certificate to practice medicine and surgery be declared eligible as contracting physicians under the Voluntary Surgical Insurance Plan.

Dr. Pitts reported the result of the mail ballot to the House of Delegates for the purpose of electing nominees to be submitted to the Hospital Service Corporation for election as representatives of the Society on its Board of Directors. He stated that the following physicians had been nominated and subsequently elected by the Hospital Service Corporation: Drs. Samuel Adelson of Newport, G. Raymond Fox of Pawtucket, Frank W. Dimmitt, Albert H. Jackvony, Philip Batchelder and William P. Davis, all of Providence.

Dr. P. F. Harrington moved that the members elected by the Society to serve as representatives on the Board of Directors of Blue Cross be given the power to act for the House of Delegates in

matters regarding the Surgical Insurance Plan, and that they also report in writing on their work at each meeting of the House of Delegates. The motion was seconded and passed.

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Meeting of the House of Delegates on March 3, 1946

A special meeting of the House of Delegates was held on March 3, 1946. Mr. Saunders, executive director of Blue Cross, was invited to address the House, and he did so reviewing the position of Blue Cross as regards the fee schedule.

The House adjourned after moving that the seven representatives of the Society on the Board of Directors of the Service Corporation act as a committee to arrange a tentative fee schedule and then submit such schedule to the Society.

* * * * *

Special Meeting of the House of Delegates March 10, 1946

At a special meeting of the House of Delegates on March 10, 1946, the question of a fee schedule was discussed by the members. Discussion was introduced relative to whether the proposed plan should be a service plan or an indemnity plan. A motion was made by Dr. Ashworth that before any action was taken on the adoption of a surgical plan, reconsideration be given to the advantages and disadvantages of both service and indemnity plans. The motion was seconded, and after lengthy discussion, it was defeated by one vote.

A motion was made that the House of Delegates take no final action on the problem of insurance until the Medical Society has had the opportunity to express itself; and further, that the House of Delegates carry out the wish of the Society when that wish is made known. This motion was seconded and after discussion it was adopted without a dissenting vote.

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Special Meeting of the House of Delegates August 28, 1946

A special meeting of the House of Delegates was called on August 28, 1946. At this meeting Dr. William P. Davis reported on the completed work of his committee and submitted printed copies of the indemnity schedule and the subscriber and physician's agreement which had been sent to each member of the House. The Committee asked to be discharged from its work and the House so voted.

The motion was made and seconded that the report of the Surgical Insurance Committee relative to the fee table and Physicians Contract and subscribers contract be accepted. The discussion that followed was highlighted by the following:

Dr. Earl Mara discussed the motion expressing the belief that the House should approve of the report but at the same time it should have assurance from the legal counsel of the Society on the technical phases of the contracts in order to protect the House of Delegates and the membership of the Society.

After discussion it was moved that the report of the Surgical Insurance Committee be accepted and approved by the House of Delegates provided the legal counsel employed by the Society approves the wording of the contracts and suggests any changes to safeguard the interests of the society; and provided further that Dr. Pitts be authorized by the House of Delegates to approve any suggested changes or additions as recommended by the legal counsel before the final draft is submitted to the Hospital Service Corporation with the complete approval of the House of Delegates. The motion was seconded.

The report of the Committee was then unanimously adopted.

The president called attention to the fact that at its March 10 meeting, the House of Delegates had moved that no final action be taken on the plan until it had been submitted to the entire membership. Then he asked for further expression of opinion. A motion was made, seconded and passed that the action taken on March 10 should be rescinded.

* * * * *

Meeting of the House of Delegates September 25, 1946

At the regular meeting of the House of Delegates on September 25, 1946, the president reviewed the study of the subscriber's contract for the surgical insurance plan relative to the clause concerning the participating physician as raised at the special meeting of the House of August 28. He reported that in conference with Blue Cross executives he was informed that they intended that doctors of osteopathy be included in the plan; and that the clause noted in the subscriber's contract was specifically intended to rule out beyond question the possible inclusion of chiropractors.

Dr. Pitts explained that at the conference meeting with the Blue Cross executives to discuss the subscribers contract, he had made a point to the group that at no time has the medical profession considered the osteopaths as qualified as surgeons under the same standards as doctors of medicine.

Dr. Pitts inquired of the legal counsel if the Blue Cross could write separate contracts. Mr. Williamson reported that the Board of Directors of the Blue Cross has authority to make contracts with anyone under the provisions of the legislation.

After this and supplemental discussion, the following motion was adopted by the House:

continued on next page

That the Rhode Island Medical Society will accept the surgical services rider to the subscriber's contract provided that Part VIII thereof, sections (a) and (b) are amended to read as follows:

(a) Participating Physician—The term "participating physician" shall mean any person duly licensed by the board of examiners in medicine under the laws of the State of Rhode Island to practice medicine and surgery, who has entered into a participating agreement with the Blue Cross.

(b) Non-Participating Physician — The term "non-participating physician" shall mean any person duly licensed by the board of examiners in medicine under the laws of the State of Rhode Island, or by any other comparable and duly authorized board of examiners in medicine in any other State, to practice medicine and surgery, who has not entered into a participating agreement with the Blue Cross.

* * * * *

Meeting of the House of Delegates January 22, 1947

The reply of Blue Cross to the request of the House of Delegates made at the meeting of September 25, 1946 was incorporated in a letter to Dr. Herman C. Pitts, president of the Society, dated January 16, 1947, abstracts of which follow:

"At the last meeting of the Executive Committee of the Blue Cross on January 9, 1947, which was attended by most of the doctors representing the Rhode Island Medical Society upon the Board, a thorough discussion was had of the entire problem of osteopathic participation in the proposed plan for non-profit prepaid surgical care."

"The plan, as developed by the Rhode Island Medical Society and the Blue Cross, has now progressed to the point where, if this one problem can be solved, steps can now be taken to put it into operation. We are all concerned primarily with the interest of the public, and hope that this service will be available to them soon. The public is entitled to expect us to find a solution without further delay.

"No one can doubt that all concerned have conscientiously sought a solution, each having in mind his own conception of the public good. Blue Cross does not seek to enter into a controversy or take sides in the two schools of the healing arts. We are primarily concerned in seeing that a workable program of non-profit prepaid surgical care is put into effect at the earliest moment possible.

"We understand that the Medical Society is seeking the same objective and that the only objection remaining is that the Society does not desire, by cooperating in the plan, to appear to lend its endorsement and approval to osteopathy. We believe that this objection can be met readily if the following program were to be adopted.

"We propose, in effect, that Blue Cross cooperate with the Rhode Island Medical Society in offering a program of prepaid, non-profit surgical care covering the services of doctors of medicine only along the lines previously outlined in our exchange of correspondence. The Blue Cross will also, upon its own account, offer a program paralleling and supplementing the Medical Society's plan, covering claims for surgical services rendered by osteopathic physicians. The Medical Society is to have nothing to do with the latter program, which will be administered solely by the Blue Cross. It will not in any sense have the endorsement of the Rhode Island Medical Society. In order to make this arrangement practicable and to keep operating costs within reasonable bounds, it will be necessary that both plans be operated by the same personnel and that benefits be paid from a common fund. It will not be practicable to keep separate records, or actuarily possible to set up separate reserves."

"We offer the above program as a means of meeting the objection voiced by the House of Delegates. . . . It is our sincere opinion that if we are not able to agree there is no point in pursuing the matter further along present lines and it would be better to seek a new approach."

(Signed)

Kenneth D. MacColl, President
Hospital Service Corporation of R. I.

The House of Delegates voted not to accept this proposal of the Blue Cross, and the following public statement was issued by the Society:

"At a meeting of the House of Delegates of the Rhode Island Medical Society held January 22, 1947, a final proposal of the Blue Cross that it would run a supplementary plan to the medical society's proposed low cost prepayment surgical insurance program, utilizing the same personnel and the same commond fund, was not accepted. The Society voted to continue its efforts to accomplish its objective of providing the public with a prepaid surgical insurance plan.

"The Blue Cross proposal was that the Society cooperate in offering a parallel plan covering surgical care by others than doctors of medicine. The Society believes that it can properly be concerned only with offering a plan to cover that segment of the public who desire the services of doctors of medicine.

"The Society is conscious of its obligation to provide the public with the highest standards of professional competence possible. It can discharge that obligation in the proposed plan only when the service rendered is under its jurisdiction."

In order to seek a new approach to the problem of placing a low cost prepayment surgical insurance plan before the public under the auspices of the Rhode Island Medical Society, Dr. Rocco Abbate moved

That a committee of five members of the Society be appointed by the House of Delegates to study ways and means of putting into effect the Rhode Island Medical Society's proposed low cost prepaid surgical plan as of its own, or through the possibility of having private insurance companies take it over.

The motion was seconded and adopted.

PROVIDENCE RECREATION PROGRAM

The recent report of the Providence Recreation Advisory Committee makes interesting reading. The recreation program of the City of Providence in years past has been much neglected, the playgrounds have had little care and the city administration and the public have taken no pride in this civic activity. The advisory committee has made valuable recommendations of which the most important seems to be "We further recommend that the Mayor appoint a seven member advisory committee to meet monthly with the Director of Education." Such a civilian committee if properly chosen, with a member from every organization having the health and welfare of our child population at heart, should exert a most important influence upon the director and his associates. Such a committee should function as a liason committee between the Providence Recreation Department, the public, and the daily press. Individual citizens are too much concerned with their own private affairs to be much interested in a play program unless stimulated by the public press. Publicity is necessary.

The report further states that "The success of this recreation program will depend largely—almost entirely—upon competent, trained and experienced leadership." Theoretically this might be true but whether we like it or not, every city or state position the country over, regardless of the qualifications of the appointee, becomes a political appointment. Gradually the functioning of any department becomes entirely dependent upon the director. The public is eliminated, loses interest and an unhealthy spirit of indifference arises in the department itself. The present condition of the city's playgrounds bears mute testimony to such a sequence of events in Providence.

Good physical and mental health should result from a properly conducted play program. Teachers employed to carry on the work should be chosen not only for their ability to teach the subject associated with the program but for their training in the handling of children. The program should be continued both summer and winter; our indoor facilities connected with our schools are good.

The care of the summer playgrounds should be delegated to the various boys' organizations in the community served by the playground. Only in this way may we expect to stimulate a sense of pride in the children who use the playgrounds; these children should be taught that they are citizens of this city, that the grounds are their personal property and their interests are best cared for by themselves. A few years ago the vandalism which resulted in the destruction of much playground equipment was interpreted by those who read between the lines, as a psychological protest on the part of the boys involved, against the condition of the playgrounds and the inadequate equipment supplied for their entertainment. No normal child, girl or boy, will wilfully destroy property in which he has a feeling of personal interest and pride.

In November, 1946, the citizens of Providence voted in favor of a million dollar appropriation presumably for the building of four new public play fields, of five acres each. Three of these are planned for closely adjoining sections—Federal Hill, Olneyville and Mount Pleasant. The fourth has been allocated to South Providence. If all the money appropriated is to be used for these highly expensive playgrounds there will be nothing left for the repair and reconditioning of some of our already existing play areas. Play lots for children of five or under all over the city should be planted to grass, shade trees should be added and there should be benches for mothers and their little children. Anyone who has examined these play lots will realize how much attention they need.

The South Providence playground bounded by Prairie Avenue, Dudley and Somerset Streets can be enlarged and equipped at a relatively small expense. The playground on Valley Street can be made into a large area for recreation. There is an excellent but poorly equipped area at the junction of Admiral and Charles Streets which with almost no expense can be reconditioned; this part of the city has been neglected in the City's plans. There are many other smaller lots of land controlled by the City which can be improved at little cost. If,

continued on next page

however, the million dollar appropriation is all spent on four new playgrounds we will find ourselves in the same predicament as formerly with an excess of property inadequately equipped for the expanded future administrative program devoted to the mental and physical health of our child population. Only an enormous increase in the playground annual appropriation can begin to take care of the old as well as the newly planned areas of recreation. One well conducted playground is a great asset to any city but a dozen poorly managed grounds constitute a liability.

While on the subject of playgrounds let us not forget that the City of Providence has also appropriated a large sum of money for building projects. Neither the Roger Williams nor the Chad Brown building projects have any arrangements for the entertainment of the children inhabiting those projects. In the future let us hope that the planners of new projects will not forget this important addition to each housing project.

SURGICAL MEETINGS

Providence becomes the surgical center of New England this year as the result of the recent announcement of the American College of Surgeons that it will conduct its sectional meeting for the medical profession of the northeastern area at Providence on March 28 and 29. Previously the New England Surgical Society had selected Providence for its annual meeting to be held on October 3 and 4.

WELCOME HOME

The Rhode Island Medical Society reports the following Rhode Island physicians as honorably released from active duty, all of whom have resumed the private practice of medicine.

HARRY E. DARRAH, M.D., 42 Woodbury Street, Providence
HARRY HECKER, M.D., 172 East Avenue, Pawtucket
ALFRED E. KING, M.D., 175 Harris Avenue, Woonsocket
JAMES W. LENT, M.D., Main Road, Tiverton
ELIHU SAKLAD, M.D., 252 George Street, Providence

PATRONIZE
JOURNAL
ADVERTISERS

STATES LAUNCH ANTI-POLLUTION DRIVES

Extended programs to curb the 5.75 billion gallons of untreated sewage dumped every day into the nation's waterways are being launched on the interstate, state, and local level according to the American Public Works Association.

Stream pollution laws were strengthened recently in Mississippi, while in Texas pollution of public waters has been made a penal offense. Local pollution surveys are being made in Texas by the state health department to determine changes and improvements needed in city and industrial waste disposal facilities.

In Oregon, 64 cities now have definite plans for new sewage disposal plants and sewer systems. Bond issues for this purpose totaling $14,995,800 have been voted in 19 Oregon cities, while 35 cities have accumulated sinking funds for sewage disposal totaling $2,324,114.

The Michigan state planning commission, meanwhile, has accepted plans for $100 million worth of sewage disposal projects, according to a recent nationwide roundup of anti-pollution activity made by Sewage Works Engineering magazine. Many of the Michigan projects are ready for construction.

The Pennsylvania anti-pollution program is centered on industrial as well as other urban wastes. The state health department has ordered 508 cities and institutions and 352 industries to prepare plans for sewage and waste treatment. Mine operators and manufacturers are being required to treat all waste discharges.

In California, sewage disposal construction has highest priority under $90 million public works construction legislation approved this year. Massachusetts and Minnesota strengthened their anti-pollution laws last year, 91 cities in the latter state having taken action in 1946 to provide for new sewerage facilities.

Because watersheds observe no geographical boundaries, several interstate agencies are acting to help curb pollution. Among these are the Interstate Sanitation Commission involving New York, New Jersey and Connecticut, and the Interstate Commission on the Delaware River. Interstate pollution control operations along the Ohio are being coordinated by means of the Ohio River Compact.

More stringent pollution control legislation is being drafted in several states. Maryland's new Committee on Water Pollution will recommend stronger anti-pollution laws to the 1947 legislature, while in Rhode Island a report on pollution is being prepared for the governor. Similar action is being taken in New Hampshire, Vermont and New York.

—Bulletin, Public Administration Clearing House.

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

CLINICOPATHOLOGICAL CONFERENCE

Rhode Island Hospital

Name: J. D. C.

Age: 63

Admitted: August 31, 1945

This patient was admitted with chief complaint of abdominal pain and inability to urinate.

This patient states he has been unable to void for 12 hours prior to admission and he has had difficulty in starting his stream with oliguria for the past few weeks. Nine hours before admission, after a heavy meal of fish, he experienced sudden onset of hypogastric and periumbilical distress which soon became a pain, and this pain became increasingly severe and gradually became generalized. At the time of admission the pain was more marked in epigastrium. He had never had any cramps, no vomiting and had never any tarry stools, but just before the onset of his pain he had a normal bowel movement.

PAST HISTORY

In the past six months this man has been having periumbilical distress coming on 20 minutes after meals.

FAMILY HISTORY

Irrevelant.

PHYSICAL EXAMINATION

Reveals an obese male in evident pain. He is slightly cyanotic and sweating. *Head:* Negative. *EENT:* Not remarkable. The *lungs* are clear to percussion except for occasional moist rales at the left base. The *heart* borders are not percussible. No irregularities or murmurs. Sounds are distant, not very well heard. Blood pressure 90/60. *Abdomen:* This is moderately distended. There is voluntary spasm in the upper abdomen and in the region of the umbilicus. There is tenderness in the epigastrium. The abdomen is tympanitic in the lower half but not in the upper half which is dull to flat. There is diminished peristalsis. A fluid wave is also felt. *Rectal* examination reveals a large, firm prostate; no masses felt. *Extremities* show no abnormalities. *Reflexes* in order.

Admission Diagnosis:

1. Acute retention
2. ? acute pancreatitis
3. ? cholecystitis

LABORATORY WORK—AUGUST 31, 1945

Blood urea nitrogen 22; glucose 132; creatinine 1.8. White blood count 8,350; 80% polymorphonuclears; 14% lymphocytes and 6% monocytes; hemoglobin 18.2.

PROGRESS NOTES

Surgical Consultation: This 63-year-old white male was admitted to the Second Surgical Service with a history of sudden periumbilical pain following a supper of fish. However, the patient has a preceding history of difficulty in starting to urinate with oliguria and nocturia. The pain was more marked in the lower abdomen which gradually spread to the entire abdomen. Examination reveled a very distressed, toxic patient sweating; lips are slightly cyanotic and cold. The abdomen markedly tender, distended especially around and below the naval. There is dullness to flatness on percussion. Rectal reveals a soft, slightly enlarged prostate. Patient has history of not voiding since 2 p. m., August 30. I believe this patient is a genitourniary case and needs a suprapubic cystotomy.

Subsequent to admission the patient was catheterized with filliforms without success. Hot-Sitz baths and morphia were used to no avail.

Genito-urinary Consultation—August 31, 1945—11:30 A. M. This man has a good size prostate with a clot in his bladder. His bladder is palpable up to his umbilicus. He is in extremis, but cannot go on with his distended bladder. He was admitted to the Surgical Service eight hours ago—will accept on Genito-urinary Service.

August 31, 1945—2:00 P. M. Operation revealed no distention of the bladder. Peritoneal cavity was full of pus. Small rubber tissue drains were inserted.

August 31, 1945 — 3:00 P. M. Patient again seen by the Surgical Service. It was stated that at present his condition was too poor and will not tolerate operation. It was felt that the patient should be back into Fowler's position and a Levine tube substituted for Miller-Abbott tube. If the patient however, gets in operable condition, laparotomy should be performed. Condition at present is very poor. He is cyanotic and presents the blood picture of overwhelming sepsis.

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Presenting

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Penicillin	"the best of the ontibocteriol drugs we now hove for the local treotment of chronic sinus . . . infections."[1]
In a Combination Package	contoining one viol eoch of dried calcium penicillin and specially buffered Neo-Synephrine Hydrochloride Solution ¼%...to be mixed just prior to dispensing. When mixed, eoch cc. contains not less than 1000 units of penicillin ot pH 6.0.
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For Use	in the treatment of ocute ond chronic sinusitis, by displocement, irrigotion or tompon . . . full strength or diluted with one part normal soline.
Supplied	as combination pockage contoining one viol each of dried calcium penicillin (opproximotely 15,000 units) ond specially buffered Neo-Synephrine Hydrochloride Solution ¼% (15 cc.). Available on prescription only.

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1 Ann. Otol., Rhin. & Laryng. 52:541, 1943.

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CLINICOPATHOLOGICAL CONFERENCE

continued from page 118

August 31, 1945. Transfusion 1,000 cc. of plasma and 1,000 cc. of blood.

August 31, 1945—8:00 P. M. Color good in oxygen tent. He is responsive and states that he feels much better than he has felt all day. Pulse is good in quality and regular. Blood pressure ranges around 90/60. At present the abdomen is distended with gas. There is no board-like rigidity although tenderness and muscle spasm on palpation are noted throughout. It is most marked now in the right side in the paraumbilical area and right lower quadrant. The onset of the illness was gradual. Now that we know that he has had a peritonitis, acute appendicitis as the underlying cause would be the first choice.

September 1, 1945—1:30 A. M. Patient seen by the cardiac resident who states that patient is now in pretty fair shape so far as his heart and pulmonary circulation are concerned. It is advised that the IV's be kept below rate of 30 drips per minute to prevent failure.

September 1, 1945. Wasserman and Hinton negative. Urine 1017, protein 2+, sugar negative. Sediment shows red blood cells many, white blood cells few and many coarse granular casts. Transfusion—1,000 cc. of blood given. Blood urea nitrogen 39, sodium chloride 425, creatinine 2.5. White blood count 12,300.

September 2, 1945. Patient is stuporous which may be due to excess morphine. Moist rales are present at both bases and the abdomen is more distended today.

September 2, 1945—3:45. Patient suddenly turned blue, began to breathe with bubbling sounds. Chest was full of moist rales. Heart sounds were weak, the pulse was 72 but very thready. Blood pressure 50/20. This episode occurred minutes after an enema was given. Expired at 3:45 P. M.

* * * * *

Dr. Edmund Laurelli: The thing that interested me was that at no time did the man definitely have signs of a peritonitis; at no time did he have a board-like abdomen. He showed spasm and he had a good deal of tenderness, which became generalized.

In discussing differential diagnosis, I am going to take the premise that he had two conditions:

1. A genito-urinary condition, and
2. A separate condition involving the peritoneum and the abdomen itself.

I think that this excludes discussion of any medical possibilities. So that we come to the first consideration, which was acute appendicitis. The onset of acute appendicitis is usually quite insidious, and the initial epigastric pain is usually mild. However, this patient came in, cyanotic, and in shock, which was too soon, I think, for appendicitis as we usually see them. But, the previous history of dyspnoea suggested other possibilities.

The next possibility which was mentioned by the interne was acute hemorrhagic pancreatitis. We don't like to pay too much attention to that because it only accounts for one per cent of abdominal trouble, but the patients afflicted with this particular type of disease usually are obese and give a history of gall bladder disease.

The initial pain of pancreatitis is agonizing and is accompanied by signs of shock. Rigidity of the abdominal muscles is not as marked as a ruptured viscus. The tenderness, if any, is continued to the upper abdominal quadrants. Very often, in pancreatitis, a mass is felt in and around the epigastrium, and there is vomiting, which this patient did not have; those are the usual symptoms of pancreatitis. In fact, the vomiting is continuous and the retching may be intractable.

Another possibility which the interne considered in his provisional diagnosis was acute inflammatory process of gall bladder. This, again, is more of a compact, clinical quantity, which does not suggest itself in this particular case. There was no right upper quadrant pain, in spite of the indigestion he had. There were no local findings leading to the right upper quadrant, and no distribution of pain typical of the gall bladder.

The next consideration, not mentioned on the admission diagnosis, was mesenteric thrombosis. This man was 63 years of age, and no doubt had cardiovascular disease. He would be a set-up for that. But again, there wasn't the violent onset that you would get with that. There were no tarry stolls, diarrhea, colicky pain, no blood in the stools, which may occur. The pain in thrombosis is constant and diffuse, and the progress of the patient tends to get progressively worse.

Then, we must consider ruptured viscus, and perhaps first in that group, a perforated, peptic ulcer. The onset is sudden in this type of case. There is usually a history of distress. But the findings in this patient were more or less enigmatic, because of no board-like rigidity. It is possible that the picture was obscure because he came in, in a second stage of perforation, in the stage of reaction, where the patient looks a little better, his color has improved, his pain is lessened, and he has a little more euphoria; he feels better. That is the stage when the perforation is misdiagnosed. But, at this second stage, although the pain is still present, it is dulled,

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"Footprints on the sands of time"—No. 4

of a series honoring the contributions of eminent personalities of medicine and pharmacy.

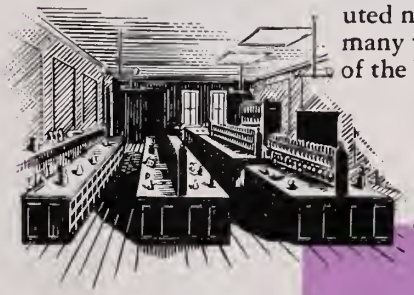
WILLIAM PROCTER, JR.-1817-1874

Pharmacist and Teacher

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CLINICOPATHOLOGICAL CONFERENCE

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and very often missed. There later develops a localizing pain in one of the lower quadrants, and in this case it was the right lower quadrant; this was found by surgical consultation. In fact, it was upon the right lower quadrant pain that the diagnosis of acute appendicitis was made, and is often mistakenly made, the reason being that the gastric contents, having spilled out into the abdomen, hit the transverse mesacolon and follow the ascending colon down to the right and there the gastric contents are pooled to form a localizing acute area.

It is with this thought in mind that I have ventured to say that the man may have had a perforated, peptic ulcer.

I should like to hear some comments on that.

DR. CLARKE: You would put peptic ulcer down as first choice, Doctor?

DR. LAURELLI: Yes, I would.

DR. CLARKE: What would be your second choice?

DR. LAURELLI: Mesenteric thrombosis.

DR. CLARKE: And you rejected the gall bladder and the apendicitis?

DR. LAURELLI: Yes. Those are the two possibilities, in the order of my preference.

DR. CLARKE: Is there any discussion on this story, from the clinical point of view?

DR. FREEDMAN: What was the cause of death? Pulmonary embolism?

DR. LAURELLI: Well, it could have been the straw that broke the camel's back. I think the man was sick with infection before he had anything else, so it could at least be a secondary cause.

DR. CORVESE: I think that from the complaints the man could have had anything. I think I favor the appendicitis. However, because of the progressive symptoms and the finding of pus, I think this man had a perforated ulcer, localizing abscess, and when he came in with signs of ruptured ulcer he was somewhat gone, so he didn't have a board-like abdomen, and he died from peritonitis and probably other complications, pneumonia, but did have probably a large prostate.

I think in spite of other signs that he had a ruptured duodenal ulcer.

DR. FREEDMAN: I am wondering about the urinary symptoms, irritation of the bladder, and the generalized peritonitis. My first guess would be a ruptured appendix.

DR. CLARKE: Is there any other discussion?

DR. GOLDOWSKY: I think there is the possibility of a neoplasm.

DR. CLARKE: Is there any further discussion? If not, we will report to you the post mortem findings, as far as we know them. We attempted, first, to dispose of the question of some terminal episode, apart from his primary illness, and here again we are a bit uncertain, although we assume that the absence of definite statements means they were not present.

A few things that have impressed me in the post mortem of both of these cases—and I am saying this largely for the benefit of my own staff, are the descriptions. There is no mention of the blood vessels in the post mortem examination. We don't know the finding on that; there is a definite lack of information there.

As far as we know, there was no terminal pulmonary embolism.

Now, the patient's abdomen had already been opened, and it was pretty well established that there was a generalized peritonitis; it remained only for the post mortem examination to reveal the sources of the peritonitis. The possibilities have been reviewed by Dr. Laurelli, and I am pleased to say that the one that he put at the top, peptic ulcer, is the one that was found at post mortem. This man had a peptic ulceration of the duodenum, which was a good-sized one, about 2 c.m. in diameter. This had perforated at the time of the post mortem. The entire peritoneal cavity was covered with purulent exudate, so the perforation which was now plugged with the omentum, had very definitely leaked at an earlier hour.

Now, in addition to the duodenal ulcer, this man had a second ulcer on the stomach side of the pyloric ring. This was a small, shallow ulcer, and only ½ c.m. in diameter.

The matter of the prostate remains again somewhat uncertain. The only statement regarded in the gross description is that the prostate is small. The bladder was not distended. I thought that I would take advantage of this opportunity to discuss rather hurriedly the pathology of peptic ulcers. The chief interest in connection with the peptic ulceration, I think, extends around the etiology. We could spend a lot of time discussing that. But we will confine our discussion to the description of the morphological changes. Ulcers of the peptic origin, of course, occur usually in the stomach or the duodenum. Other rare locations are the lower end of the oesophagus, and occasionally in the diverticulum; also occasionally in the jejanum, following surgical anastomosis, between the stomach and the jejunum.

The lantern slides which we present will be a mixture of duodenal and gastric ulcers, but you will find quite applicable to either one.

The location of the gastric ulcer is most commonly near the pylorus, and towards the lesser curvature side, and since this happens also to be the most common case for gastric malignancy as one of the reasons, there has been some suspicion

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CLINICOPATHOLOGICAL CONFERENCE
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thrown upon peptic ulcer as a starting point for malignancy. By the time the pathologist sees these ulcers, they usually are rather deep and they extend, involving the stomach or the duodenum, as the case may be. Textbooks are very fond of describing them as being like stair steps, something like this (showing slide). It is true that they, occasionally, are stair steps, but more often they are cup-shaped or cone-shaped, rather than terraced, or stair-steps.

Along with the destruction of normal tissues, there is a defense reaction on the part of the body, which is a repair reaction, in the production of granular tissue which, as it becomes older, lays down cologen and becomes scar tissue. So that always, unless it is an acute ulcer, there is an advance of the actual defect with granular tissue, and then fibrous scar tissue. This may reach the proportions that the stomach or duodenal wall becomes many times its normal thickness.

The first lantern slide shows a gross specimen as an illustration of an ulcer of the duodenum, and this represents the pyloric range, and this is the gastric side of the material (indicating in slide). This is the duodenal ulcer. They tend to be rounded, although irregular in shape, rather punched out. The wall may overhang a little bit, on the gastric side, they tend to overhang in the upstream direction, and they slope off towards the pylorus. So that this is a rather typical appearance of a moderately sized and moderately deep duodenal ulcer.

This, likewise (showing slide) is a duodenal ulcer, this one being not so deep and not so much fibrous scar tissue.

This (showing slide) is, to all intents and purposes, much like the two we have just seen. This is located on the gastric side of the pylorus, and the walls of this are thickened; the defect extends entirely through the muscles, so the underlying tissue which you see in the bottom of the ulcer is fibrous scar tissue.

These have a tendency, when they are located at the pyloric ring, to extend so as to encircle the lumen, and here is an ulcer (showing slide); this is the pylorus, and this suggests the gastric side; this extends laterally, so that it encircles the entire lumen at that point.

Ulcers are not infrequently multiple. We have mentioned duodenal and gastric ulcers today. Here is a multiple ulcer (showing slide). And here is another example of multiple gastric ulcer (showing slide); these are acute ulcers. There is no fibrous reaction about them; they are all very acute, and they involve just the mucosa. These were found in a patient who post-operatively developed thrombosis of the splenic artery and the coronary arteries of the stomach.

When they extend through the wall, fortunately and not infrequently they do so adjacent to some other organ, and this reparative reaction is sufficient to sew the two structures together, so that while the stomach wall is entirely perforated, it doesn't leak into the peritoneal cavity.

The next slide shows a cross section through an ulcer, the purpose being to show first the shape and the depth of the ulcer crater; then to show the great increase in thickness of the wall about the ulcer, due to the laying down of the fibrous scar tissue.

Here is another one, and it is a poor photograph, but it shows the cup-shaped one, while the other is more cone-shaped.

This next slide represents a stomach, and on top of it, laid open, is the jejunum, and this is the orifice, and at the periphery of this orifice or near it is this great peptic ulceration in the jejunum.

Histologically, there is a characteristic picture that is found. There is a very low-powered and a small ulcer, so that we have all of the field, the mucosa almost overhangs, with a defect through it (showing slide). Since we can't see the muscle on either side, we don't know how deep this goes, from the section shown, but there is in the ulcer, and always there is on the surface, even when it is much larger, some exudate, and perhaps a little debris from intestinal contents, and beneath that, there is a layer of tissue, which is a cellular, stained with pink, and it represents the progressive digestion of tissue, and the gastric juices, and are spoken of as the peptic membrane. External to that is granulation tissue, and if you go further out, there is scar tissue.

Here is a photograph, or a photomictograph, showing one edge of it. This one slopes off slowly. It is a cup-shaped, rather than a cone-shaped ulcer, but there is no stair-stepping. It illustrates the exudate, peptic membrane, with granular tissue and scar tissue. The next slide shows you a higher magnification, which brings out better the pink staining peptic membrane and also in this magnification, I think you can see particularly here that this granulation tissue is extremely vascular; these little red spots (indicating) represent capillaries, and patients frequently have blood in the stool, although no gross hemorrhage.

The next slide shows a photomictograph of the same area, greatly enlarged, to show how very vascular the tissue is.

These ulcers tend to shield and in the histological preparations, the evidence we have of healing, is this. Of course, if the thing is attempting to heal on the surface, the epithelium from the adjacent one goes out over the defect, and we can see the epithelium standing out here in this particular specimen. There is a definite attempt at repair. It doesn't replace new ones, but it covers them only

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CLINICOPATHOLOGICAL CONFERENCE

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with a layer of two or three rows of cells.

The complications of ulcers are, of course, perforation, as we have seen this morning, hemorrhage from larger vessels or from capillaries just seen.

This is a large, gastric ulcer (showing slide), and in its base is exposed a very large artery, which proved to be the splenic artery, and there is a defect there. This patient died of hemorrhage around the splenic artery. More often, instead of such large vessels, you see on the base of the ulcer fibrous scar tissue and numerous little arteries here, and patient died of hemorrhage; you can see a hemorrhagic spot.

Upon histologic examination through such an artery, we see this picture (showing slide). Here is the vessel longitudinally, with blood in the lumen, and this is the ultimate base (indicating) and this opens directly in the lumen or the stomach.

Here is a duodenal ulcer, and the white that you see in the base this time is a white cloth, upon which specimen was placed. The external surface of the specimen, I show you here (showing slide).

Is there anything that you wish to add, Dr. Laurelli?

DR. LAURELLI: We had x-rays on the patient, but they were inconclusive at the time taken, and wouldn't have led to a diagnosis.

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1. Kugelmass, I. N.: Newer Nutrition in Pediatric Practice, p. 345, Lippincott, Philadelphia, 1940.

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PROVIDENCE MEDICAL ASSOCIATION

THE one hundredth annual meeting of the Providence Medical Association was held at the Medical Library on Monday, January 6, 1947. The meeting was called to order by Dr. Paul C. Cook at 8:30 p. m.

Dr. Cook announced that in view of the lengthy program planned the reading of the minutes of the previous meeting would be omitted unless there was a vote otherwise by the members present. The reading of the minutes was omitted.

Dr. Frank B. Cutts, Secretary, presented his annual report in which he reviewed the activities of the Association during the past year. Dr. Frank W. Dimmitt moved that the Secretary's annual report be accepted and placed on file. The motion was seconded and adopted.

In the absence of Dr. William P. Davis, Treasurer, Dr. Frank B. Cutts presented the annual report of the Treasurer. Dr. Robert R. Baldridge moved that the report be accepted and placed on file. The motion was seconded and adopted.

Dr. Frank B. Cutts reported for the Executive Committee as follows:

1. That no counter nominations to the slate of officers as presented to the membership by the Executive Committee had been received.
2. That the Executive Committee presented an estimated budget for 1947 for the Association in the total amount of $7,360.08 for which it recommended the assessment of annual dues of $15.00 for each active member and $5.00 for each associate member.

Dr. William M. Muncy moved that the budget as submitted by the Executive Committee be accepted and approved and that the dues as recommended by the Executive Committee be adopted for 1947. The motion was seconded and unanimously adopted.

3. That the Executive Committee recommends that the term of elected members to the Executive Committee of the Association be three years instead of five years, and therefore, it submits as an amendment to the By-Laws that the first paragraph of Section 8 of Article 1 should read as follows:

"The Executive Committee shall consist of the President, the Vice President, the Secretary, and the Treasurer ex-officio, and of ten members elected by the Association. Members elected on and subsequent to January 6, 1947, shall be elected for a term of three years."

Dr. Frank W. Dimmitt moved that the proposed amendment to the By-Laws be adopted. The motion was seconded and unanimously passed.

Dr. Paul C. Cook delivered his presidential address on the topic of "Rhode Island's Water Pollution Problem."

continued on page 134



GUY W. WELLS, M.D.
President, 1947
Providence Medical Association

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THE ADVANTAGES of one-injection control of diabetes can, through adjustment of diet and dosage, be made available to the majority of patients requiring insulin. In view of the convenience and freedom afforded by the unique intermediate action of 'Wellcome' Globin Insulin with Zinc, the necessary adjustment is well worth while. Though not a complicated procedure, the regulation of carbohydrate balance warrants reiteration because of its importance:

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PROVIDENCE MEDICAL ASSOCIATION

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After Dr. Cook's presentation a motion picture entitled "Clean Waters" was presented through the courtesy of the General Electric Company, demonstrating pollution in its various phases and means of combating it. It showed how sewage disposal plants worked. There are 6,000 in operation now in the country, but 10,000 more are needed.

Dr. Cook called for nominations for officers of the Association for 1947. Dr. Peter Pineo Chase moved that the Secretary be instructed to cast a unanimous vote for Dr. Guy W. Wells as President of the Association for 1947. The motion was seconded and passed. Dr. Cook appointed Drs. Herman A. Lawson and George W. Waterman as a committee of two to escort the new President to the rostrum. Dr. Wells briefly acknowledged the honor paid to him by the Association in elevating him to the Presidency.

Dr. Wells then called for nominations for the other officers of the Association. Dr. George Waterman moved that the entire slate as recommended by the Executive Committee be declared the elected officers of the Association. The motion was seconded and unanimously adopted.

Dr. Wells reported that the chairman of any committee might have the floor to amplify his report already made in writing which will be published in the RHODE ISLAND MEDICAL JOURNAL in the near future.

Dr. Peter Pineo Chase took the floor to briefly comment on the problem of water pollution and to introduce a motion from his committee with the recommendation of its adoption. The motion was as follows:

WHEREAS the pollution of the waters of Rhode Island constitutes a health menace to the people of this State, and

WHEREAS this situation has been presented to the Providence Medical Association through its Committee on Water Pollution during the past year, and

WHEREAS Doctor Paul C. Cook, retiring President of the Association, has vividly reviewed the problem in his address this evening, and has pointed to the public apathy concerning the matter of pollution of our Bay and subsidiary waters, therefore,

BE IT RESOLVED the Providence Medical Association strongly protests the failure to eliminate such pollution, and also urges upon the Rhode Island Medical Society that it seek to arouse public interest in effective Statewide anti-pollution measures for the better health protection of the citizens of this State.

As the motion was seconded, Dr. Wells called for a vote and the resolution presented by the Committee on Water Pollution was unanimously adopted.

Dr. Wells announced that the meeting of the Association on Monday, February 3, would be a joint meeting with the State Medical Society at which two outstanding physicians would address the membership.

Dr. Wells announced that the complete list of appointments to Committees of the Association for the year 1947 would be published in the MEDICAL JOURNAL and each man would be notified individually of his appointment.

Dr. Wells then introduced Dr. Alex M. Burgess who conducted a panel discussion on the "Residency and Fellowship Program at the Rhode Island Hospital." The following physicians participated: Charles L. York, M.D., Herbert F. Hager, M.D., Michael DiMaio, M.D., Wilbur Mantner, M.D., and William J. H. Fischer, M.D.

The presentations of the men were as follows:

Dr. York, Senior Resident, presented a paper on Homologous Serum Jaundice. A case was presented of a patient who died of hepatitis several months after receiving pooled plasma.

Dr. Herbert Hager presented a case of Mediterranean Anemia.

Dr. Michael DiMaio gave a talk on Liver Function in Congestive Heart Failure. He pointed out that changes in Bilirubin occur even in early stages of heart failure.

Dr. Wilbur Mantner presented his studies on liver function showing that fatty liver is common in disease, particularly Thyrotoxicosis and this leads to drop in plasma protein postoperatively.

Dr. William Fischer talked on Plasma Volume.

The meeting adjourned at 10:35 p. m.

Collation was served.

Attendance—105.

Respectfully submitted,

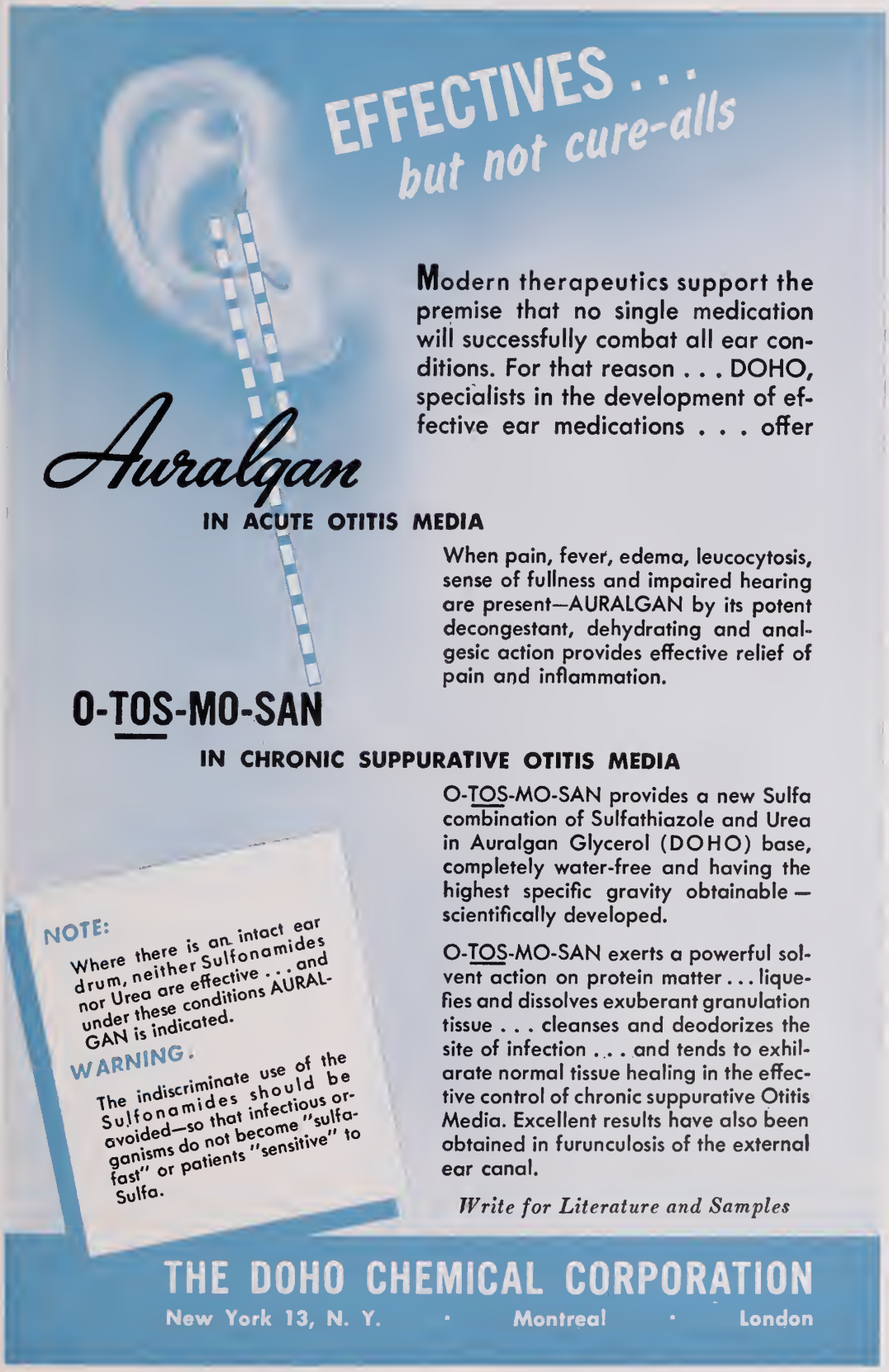
DANIEL V. TROPPOLI, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

A regular monthly meeting of the Pawtucket Medical Association was called to order by the President, Dr. Kalcounos, at 9:00 p. m. Thursday evening, December 9, 1946, in the Nurses' Auditorium of the Memorial Hospital. The minutes of the previous meeting were read and approved.

The application of Dr. Louis E. Hanna for membership in the Association was submitted to ballot and unanimously approved. Applications for membership of the following physicians were read and referred to the Standing Committee:

continued on page 136



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PAWTUCKET MEDICAL ASSOCIATION

continued from page 134

Rocco Bruno, M.D., James G. Chapman, M.D., Nathan Sonkin, M.D.

Mention was made of a special accident and sickness insurance plan offered to the Association by the Loyalty Group Insurance Company. No action was taken on this.

A report from the House of Delegates of the State Medical Society was given by Dr. Earl J. Mara. Dr. Mara said that at the last meeting of the House of Delegates several problems were raised which were considered best solved by the individual state medical groups. He discussed the following:

1. The creation of a Women's Auxiliary in the Pawtucket Medical Association.
2. The question of increasing the yearly dues of the Rhode Island Medical Society to $40 yearly.
3. The pre-payment surgical plan forwarded to the Blue Cross which was held up pending the acceptance or rejection of including osteopaths in the group.

Dr. Kalcounos remarked that the plan for the Women's Auxiliary was patterned after the AMA Auxiliary and it was hoped that the wives of physicians might enlighten their respective women's clubs about current medical economic trends.

Dr. Krolicki made a motion that the Pawtucket Medical Association go on record as approving the work of the delegates on the state pre-payment surgical plan and as opposing the joining with osteopaths. The motion was seconded and passed.

Dr. Charles Farrell, speaking as state delegate of the American Society of Physicians and Surgeons, said that the National Association of Education, a group entirely unrelated to medical organizations, had sent to the High Schools of the country as a topic of debate the question of State versus Private Medical Practice. He asked if the Medical Society was interested in donating $50 as a prize for the best essay on such a topic, with the State Society to contribute a larger prize in the hope of stimulating high school students in the consideration of medical care. He added that he would be willing to contribute the $50 himself. Dr. Farrell also briefly discussed some of the activities of the A.S.P.S. in guiding medical legislation.

Dr. Frank Hanley made a motion that the Pawtucket Medical Association approve the essay contest but defer action until the attitudes of other medical groups in the state were considered. This motion was seconded and passed.

Dr. Frank Hanley then presented a film, "Doctors and Industry" following which the meeting adojurned and refreshments were served.

* * * * *

A regular monthly meeting of the Pawtucket Medical Association was called to order by Dr. Kalcounos at 9:00 p. m. in the Nurses' Auditorium of the Memorial Hospital.

Reading the minutes of the previous meeting was omitted.

The application of Bencel L. Schiff for membership in the Association was read and referred to the Standing Committee.

Dr. Kalcounos spoke briefly of Rhode Island Medical Society membership. He mentioned the fact that all but sixteen members of the Providence Medical Association belong to the State group.

Dr. Thad Krolicki introduced the guest speaker, Dr. E. Parker Hayden, Chief of the Rectal Clinic, Massachusetts General Hospital. His topic was "Diagnosis and Treatment of Common Ano-Rectal Disorders."

Following a preliminary discussion, the speaker presented a series of lantern slides illustrating some of the disorders mentioned, particularly carcinoma of the rectum.

Later Dr. Hayden answered numerous questions from the floor and many invited physicians participated in these remarks.

The meeting adjourned at 10:00 p.m.

Respectfully submitted,
KIERAN W. HENNESSEY, M.D., *Secretary*



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ANNUAL REPORTS FOR 1946

PROVIDENCE MEDICAL ASSOCIATION

ANNUAL REPORT OF THE SECRETARY

Providence Medical Association, January 6, 1947

During 1946 the Providence Medical Association held eight meetings of which one was a joint meeting with the Rhode Island Medical Society held in February. The attendance at the meetings averaged one hundred members. The topics presented and the speakers at the meeting were as follows:

January 7—Presidential Address. B. Earl Clarke, M.D.
"Pulmonary Embolism and Infarction." Benjamin Castleman, M.D., of Boston.

February 4—"Medical Care for the Veterans." Major General Paul R. Hawley, MC, assistant administrator of Veterans Affairs, Washington, D. C. "The Plan for a Voluntary Surgical Insurance Program for Rhode Island." Herman C. Pitts, M.D.

March 4—Panel Discussion: "Acute Respiratory Diseases." Alex M. Burgess, M.D.; Harold G. Calder, M.D.; Francis B. Sargent, M.D.; and Morgan Cutts, M.D.

April 1—Panel Discussion: "Experiences in World War II." Guy W. Wells, M.D.; Kenneth G. Burton, M.D.; Alphonse R. Cardi, M.D.; Samuel D. Clarke, M.D.; and Nicholas A. Pournaras, M.D.

May 6—Case Report: "Quartan Malaria Following Transfusion." William J. H. Fischer, Jr., M.D.
"Thrombo-Embolic Disease — Prevention and Treatment." Robert R. Linton, M.D., of Boston.

October 7—Case Report: "Congenital Anomalies of the Great Vessels." Eugene A. Field, M.D.
"Present Procedures and Problems in a Neuro-Psychiatric Out-patient Service." David G. Wright, M.D.
"Neuro-Psychiatric Disorders — Office and Hospital Treatment." Hugh E. Kiene, M.D.

November 4—"Medical Aspects of Atomic Bombings." Shields Warren, M.D., of Boston.

December 2—Case Report: "Simple Cyst of the Renal Pelvis." Vincent J. Oddo, M.D.
"Treatment of Hypertension with Rice Diet." Fritz Behrendt, M.D. and Alex M. Burgess, M.D.
"Primary Bronchogenic Carcinoma," Joseph N. Corsello, M.D.

The Executive Committee of the Association met regularly during the year to transact the business of the Association and to initiate proposals to the membership at regular meetings. Highlights of the 1946 year included the formation of a committee by the State Medical Society to improve medical-dental relations, a study of the feasibility of a central telephone exchange, a survey of membership to secure a listing for emergency home calls either night or day, a review of the fee schedule for home and office visits, the awakening of public interest in the need for a more effective smoke ordinance, the opening of the Medical Library three nights each week, the microfilming of some of the Association's early records, efforts to secure office space for physician-veterans and for the removal of the zoning restrictions in some areas, the waiver of dues for physician-veterans for a period of six months after return to private practice, the continuance of display advertisements in the *Providence Journal* announcing the return to practice of members who had served with the armed forces, and the successful annual dinner and golf tournament held last fall.

The membership has continued to increase, with a total of 594 recorded at the end of the year. This number breaks down into 575 active members and 19 associate members. Thirty-four members were elected to the Association in 1946, six were granted a leave of absence, five transferred to other medical societies, one member was re-instated, three were granted associate membership, one was retired, and four were dropped.

During the year the following members of the Association died:

Michael B. Milan, M.D. (January 20)
Edward Campbell, M.D. (January 26)
John M. Peters, M.D. (January 27)
Raymond G. Bugbee, M.D. (February 3)
Michael J. O'Neil, M.D. (February 2)
Alanson D. Rose, M.D. (February 19)
Howard Keefe, M.D. (March 13)
James A. Gilbert, M.D. (May 17)
Dennett L. Richardson, M.D. (September 6)
Irving S. Cook, M.D. (September 9)

Finally, I wish to thank our executive secretary for carrying most of the onus of my office. A fact is worth emphasizing that by now must be quite evident to our membership—namely, the increasing value of the executive secretary to our organization. In these times when, to protect the public and ourselves, we must consider complex political, economic and legislative problems on a local and a national scale, his office has collected and has on file a large amount of helpful data. He has made many valuable contacts with newspapers, legislators, public officials and various national organizations. With him and his office we are prepared to meet the problems that face us. I believe our Association owes much to the late Dr. William Streker for his vision and energy in creating the office of executive secretary, and to Mr. Farrell for his efficiency and industry in filling it.

Respectfully submitted,

FRANK B. CUTTS, M.D., *Secretary*

January 6, 1947

ANNUAL REPORT OF THE TREASURER, 1946

Providence Medical Association

RECEIPTS		
Cash on hand, January 1, 1946	$1,658.72	
Memembership dues—		
Payments on 1945 dues	120.00	
Payments on 1946 dues	5,940.50	
Payments on 1947 dues	57.50	
Dividends from investments	47.50	
Cash Assets		$7,824.22

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Mattress of Fiberglas for hospital incubators



Now available to hospitals, a new kind of mattress assures safety, sanitation and comfort when used in incubators. Made of Superfine Fiberglas fibers for the filler, and treated Fiberglas Cloth for the covering—there are no allergy-producing materials in the mattress. It affords great comfort because the Fiberglas fibers are resilient and fluffy.

The mattress is completely fire-safe. It can be sterilized in standard equipment. Like other Fiberglas base materials, neither the filler nor the cloth will mildew or decay. The fluffy Superfine Fiberglas filler absorbs a negligible amount of moisture—dries out rapidly without affecting its physical characteristics.

The mattress illustrated was fabricated by Professional Specialties, Inc., of St. Louis, using basic materials manufactured by Owens-Corning Fiberglas Corporation.

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Winston-Salem, North Carolina

ANNUAL REPORTS

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EXPENDITURES

Committees	$100.00
Collations	475.00
Purchase of Journals and books	429.19
General Expenses	1,069.18
Opening Library Nights	177.00
Office Supplies and Equipment	191.41
Printing and Postage	275.32
Rhode Island Medical Society (Use of building, insurance, etc.)	778.08
Salaries	3,152.46
Taxes (Withholding on wages)	342.31
Telephone	169.82
Total Expenses	$7,159.77
Cash balance, January 1, 1947	$ 664.45
Membership dues outstanding	140.00
Investments	
U. S. War Savings Bonds	$2,740.00
Total Assets, Jan. 1, 1947	$3,544.45

Respectfully submitted,

WILLIAM P. DAVIS, M.D., *Treasurer*

AIR POLLUTION

The Providence Medical Association began its study of the problem of air pollution within the greater Providence area in January, 1945. In April, 1945, a Planning Committee proposed an up-to-date improved air pollution ordinance to facilitate law enforcement. (At the "Better Providence Meeting," sponsored by the Chamber of Commerce, held October 17, 1945, several endorsements were made relating to the control of air pollution, among which was the suggestion that the mayor appoint an advisory committee to review the present smoke abatement ordinance or a new ordinance.) A Civic Committee was appointed by Mayor Roberts in November, 1945, and this committee, after considering this situation, voted that the present ordinance was inadequate. In March, 1946, an Enabling Act, which came out of the Providence Medical Association's Subcommittee on Air Pollution was endorsed by the Civic Committee. It was felt that it would pave the way for a modern improved ordinance, and be flexible enough to allow other communities in the state to set up individual ordinances for protection against local conditions. In April, 1946, the above Enabling Act was passed by the General Assembly. In September, 1946, a model ordinance, published by the American Society of Mechanical Engineers, was presented to Mayor Roberts, and adoption urged by the City Council. This ordinance is a comprehensive and modern form of regulation, which, if enforced, would control the air pollution situation in the city of Providence. This ordinance passed a first reading of the City Council, but at the meeting of November 19 it was decided to present this problem at a public hearing, and the date set for December 2.

The public hearing was held at City Hall December 2, 1946. At this hearing the new ordinance was thoroughly examined. Several suggestions and changes were introduced by the members or representatives of industrial groups present, and the ordinance was held up. Subsequently, the Civic Committee met with representatives of industrial groups on December 9 and 16, and the ordinance was endorsed by the Committee and all concerned, after suggested changes had been incorporated into the ordinance.

It was now found that the ordinance could not be passed this year without calling a special Council meeting. The situation was discussed with Mayor Roberts, who said he would call a special meeting if our group so petitioned, but that the wisdom of this procedure for one ordinance might be questioned. The Mayor stated that he was personally in favor of the ordinance, and felt that he could almost guarantee that it would be passed early this coming year.

Professor Kissler, chairman of the Civic Committee on Air Pollution, appointed by Mayor Roberts, met with your chairman and in view of the situation as presented, it was thought wise not to press for a special meeting at this time, but to expect early 1947 action on the new ordinance by the City Council.

EDWARD S. CAMERON, M.D., *Chairman*
FRANK M. ADAMS, M.D.
B. EARL CLARKE, M.D.
ALEX M. BURGESS, M.D.
ANTHONY CORVESE, M.D.

READING ROOM

The Reading Room Committee of the Providence Medical Association authorized the purchase of thirty-seven periodicals for the Medical Library during 1946. Of these, four were published in England; thirty-three in the United States. One new journal, OCCUPATIONAL MEDICINE, was added this year.

Six of the journals are in the field of general medicine; the remainder are divided among nineteen different specialties.

The Association has paid for the binding of eighty-six volumes and forty-nine are at the bindary at the present time. Binding continues to be a slow process, due to a shortage of skilled labor, but the Barnard Company has managed to keep up its high standards of workmanship and materials in spite of wartime difficulties.

Evening hours at the Library were started April 16th and continued through June 13th when the summer schedule went into effect. They began again on September 17th and are continuing at present. The Library has been open a total of fifty-nine nights and has had sixty readers. In the period from September 17th through December 19th, twenty-five of the visitors have been doctors; twelve, laymen.

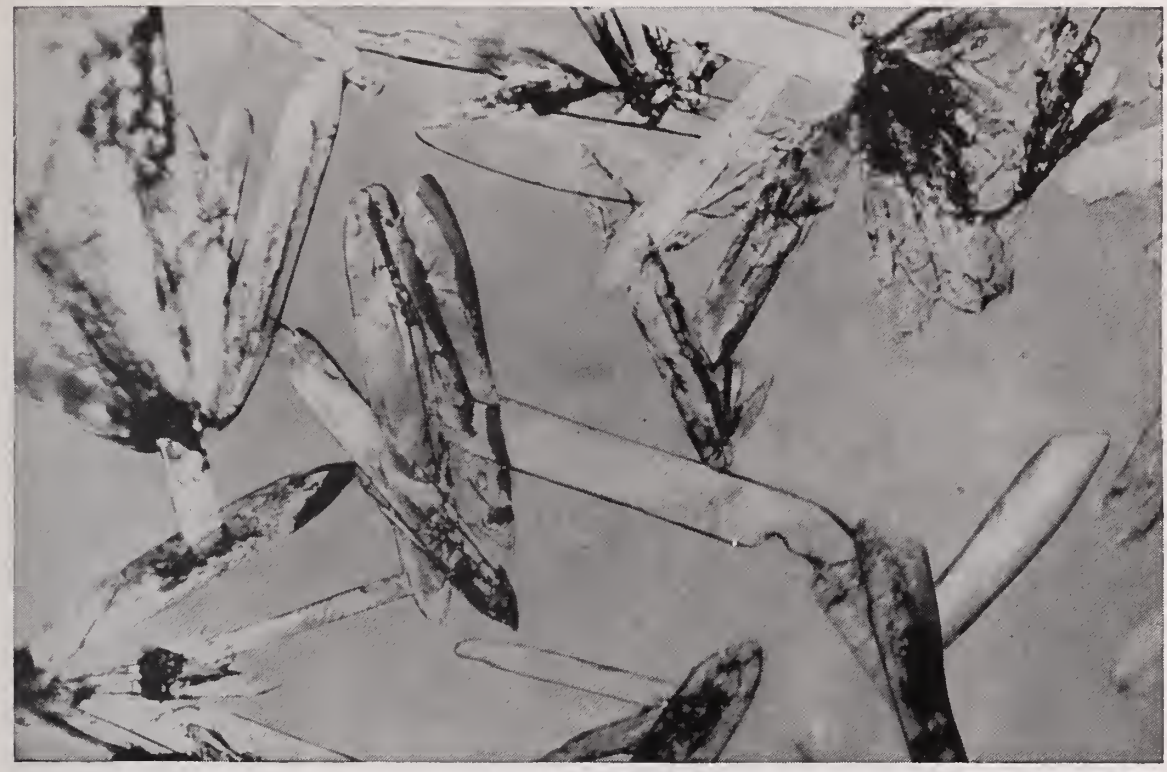
ROBERT R. BALDRIDGE, M.D., *Chairman*
KENNETH G. BURTON, M.D.
ROBERT G. MURPHY, M.D.

ADVISORY COMMITTEE OF THE COMMUNITY WORKSHOPS, INC.

There has been no occasion to hold a meeting of the entire committee during 1946. The Executive Committee of the Community Workshops has consulted the chairman of your committee on occasion, and members of your committee have assisted the Community Workshops in a number of matters which did not require concerted action.

CLIFTON B. LEECH, M.D., *Chairman*
RAYMOND F. HACKING, M.D.
WILLIAM A. HORAN, M.D.
LOUIS B. SAGE, M.D.
NATHAN A. BOLOTOW, M.D.
CATHERINE ZOURABOFF, M.D.
JOHN LANGDON, M.D.

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★ Therapeutically inert materials which may act as allergens have been virtually eliminated.

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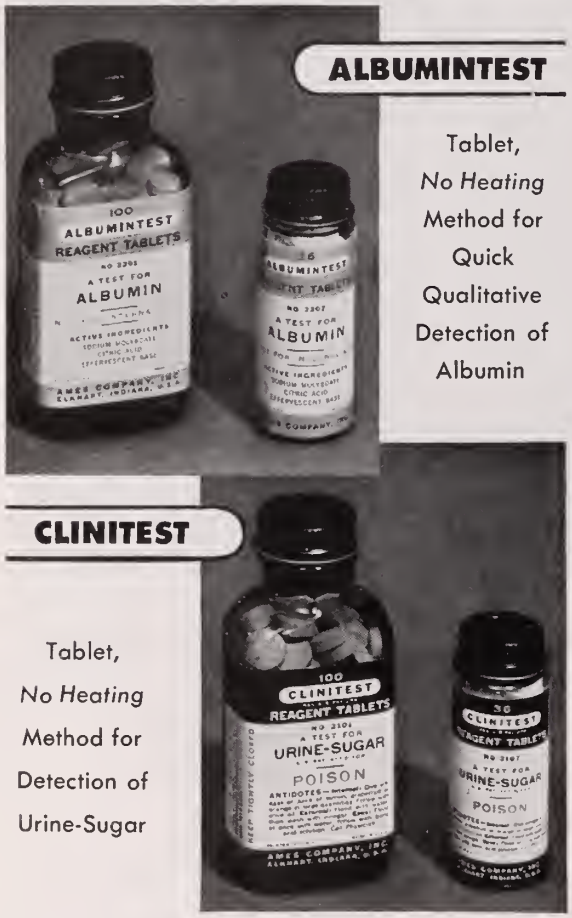
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ANNUAL REPORTS

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NURSING

The Committee on Nursing, as in the past, has been an advisory one principally to the Providence District Nursing Association. It has not met formally this past year, but its members have been consulted on occasions about problems concerning the Association.

KALEI K. GREGORY, M.D., *Chairman*
HENRY E. UTTER, M.D.
JOHN G. WALSH, M.D.
ELIHU S. WING, M.D.
JAMES H. FAGAN, M.D.

ENTERTAINMENT

The Committee on Entertainment has arranged and provided for the collation following each regular meeting of the Association. It is particularly grateful to our executive secretary, Mr. John E. Farrell, for attending to the details of this function.

It is happy to report that the annual dinner and golf tournament was held at the Wannamoisett Country Club on October 9, 1946. A record attendance of members and their guests was registered at the links as well as at the dinner. The President's Cup was awarded by our president, Dr. Paul C. Cook, to Dr. Harry E. Darrah for low net score.

Every member who attended the dinner was the recipient of a valuable and attractive door prize. The performance of a professional entertainer was received with considerable enthusiasm and enjoyment. All comment received by your committee was most favorable.

HERMAN P. GROSSMAN, M.D., *Chairman*
NATHAN BOLOTOW, M.D.
E. WADE BISHOP, M.D.
RALPH DILEONE, M.D.
CARL D. SAWYER, M.D.

PHYSICIAN-VETERANS

At the close of the year all but approximately fifteen members of the Association have resumed practice or are pursuing postgraduate work under civilian jurisdiction after service with the armed forces. During the year the Committee, with authorization from the Executive Committee, published display advertisements in the *Providence Journal* under the caption, "Your Doctor is Back." These advertisements, paid for by the Association, appeared in the *Providence Journal* on November 22, 1945; December 25, 1945; January 20, 1946; March 3, 1946; April 21, 1946; June 23, 1946; October 6, 1946. It is the belief of the Committee that these displays have been most helpful to the individual physician as well as to the public, in view of the fact that many of the men returning from the armed forces have established their offices at new locations and have new telephone listings not published in the directory this year.

In conjunction with the Executive Office and the Executive Committee efforts were made to assist returning veterans in securing office locations. Real estate agencies throughout the city were appealed to, and a news story was published in the *Providence Journal* citing the need for office spaces. The Executive Office has been of great service to the physician-veterans individually in supplying them with information to assist them in re-establishing their private practice.

A subcommittee of the Executive Committee sought assistance from the City of Providence relative to zoning

continued on page 146



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restrictions in certain areas where physicians desire to locate.

The Committee is aware of the fact that it has been limited in its ability to assist every returning physician-veteran with his individual problem, but it has made every effort to place the facilities of the Association at the disposal of such men. The Committee feels certain that the work of the Executive Office has been appreciated by the physician-veterans.

ALBERT H. JACKVONY, M.D., *Chairman*
GUY W. WELLS, M.D.
RUSSELL S. BRAY, M.D.
HENRY S. JOYCE, M.D.
JAMES FALLON, M.D.
JAMES P. DEERY, M.D.
G. EDWARD CRANE, M.D.
E. WADE BISHOP, M.D.

PRE-SCHOOL EXAMINATIONS

The major health activity of the Congress of Parents and Teachers, according to Mrs. E. Gardner Jacobs, health chairman in Rhode Island, is the so-called Summer Round-up or pre-school health examination project. The object of this activity is to prepare as many children as possible, physically, for their first years at school. To accomplish this aim, the parent-teacher organization has enlisted the cooperation of the school departments, local health authorities, medical societies, and private physicians, all of whom have been most generous in helping to develop a statewide pre-school health program.

The type of Summer Round-Up program varies in different communities depending upon the need, facilities and personnel available. In general, the practice in smaller communities is to arrange for health clinics, where children are taken at certain specified times for examination, vaccination, and diphtheria immunization. In the larger centers, however, the usual procedure is for the examination to be made by the family physician in the spring or early summer preceding the child's entrance in school. This early examination is urged in order to give the physician time to correct any defects in the child's physical condition during the summer.

In Providence, during the year 1945-1946, an admirable plan was developed by the school department in consultation with the parent-teacher organization. A series of spring meetings were planned in the schools for the mothers of all children who were to enter school in the fall of 1946. The purpose of these meetings was not only to increase the effectiveness of the Summer Round-Up program in Providence; but, much broader in scope, it was to prepare the children for their new life in school. Mothers were informed regarding the mental, social and physical adjustments the children should make as they entered school. Health, nutrition, school regulations, clothing, the child's mental adjustment, etc., were discussed, and were an invaluable aid to the mothers who attended.

Largely because of these meetings nine (9) elementary Parent-Teacher Association Units in Providence sponsored summer round-ups in 1946. Twenty-three (23) units in other parts of the State also developed similar programs, making a total of thirty-two (32) elementary units participating in this pre-school health project.

As might be expected, such a movement as Summer Round-Up has been one of slow growth, largely because many parents still do not understand that it is important to have their child examined *before* he enters school. They know that the school health department will give the child

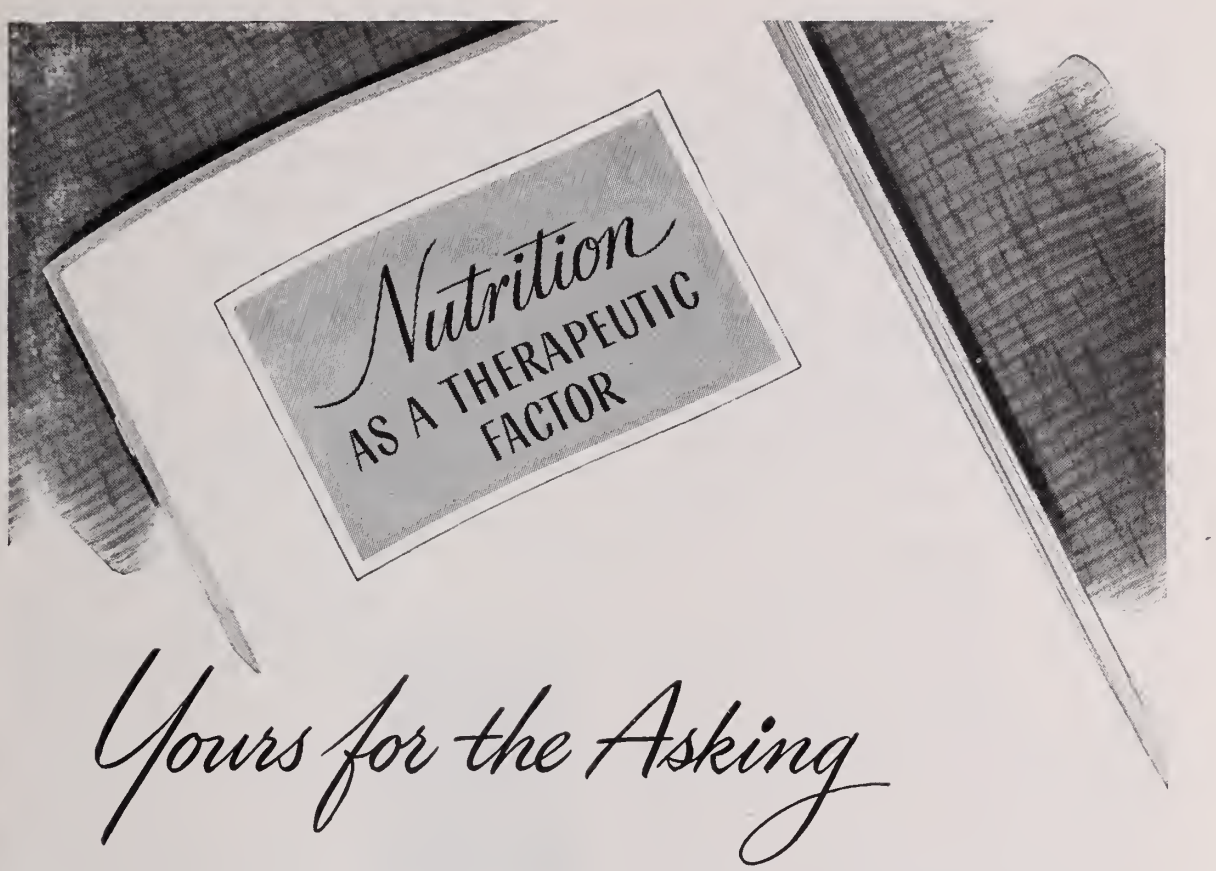
continued on page 148



the clinician knows

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ANNUAL REPORTS

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a physical check-up during his first year of school, so many prefer to wait until then. Experience has shown, however, that when the child is not given a pre-school health examination, the correction of defects usually is deferred until the child is well along in school, handicapping him unnecessarily during his early school years, and making the defect more difficult to correct as time goes on.

Although the pre-school examination is not as prevalent as we would like, we are greatly encouraged by the generous support and cooperation in the movement by school and medical authorities, by an increasing awareness of its importance by the general public and by the yearly increase both of P. T. A. units sponsoring Summer Round-Up, and of parents participating in its program.

The committee of the Association serves mainly as an advisory group on the medical procedures involved in the pre-school round-up. During 1946 it was not necessary to hold any meetings. The results of the 1946 campaign will be tabulated later.

CHARLES B. LEWIS, M.D., *Chairman*
ROBERT M. LORD, M.D.
MERLE M. POTTER, M.D.
MICHAEL J. NESTOR, M.D.
TEMPLE BURLING, M.D.
LINLEY C. HAPP, M.D.

WATER POLLUTION

The Committee on Water Pollution which was appointed last winter held several meetings. Fortunately, we got in contact with Mr. Robert S. Preston who was Secretary of the Committee on Water Pollution of the State Planning Board, which Committee was active for several years before the War. He gave us access to their records and we soon learned the more important aspects of the situation.

The problem is an enormous one. It will take many millions to make our waters reasonably clean. The engineering firm who were considered for making a survey and determining the major details of the problem asked over $100,000 just for this.

It was evident that the situation presented an analogy, to Calvin Coolidge's minister who preached on sin and was "agin" it. So we are all against water pollution. So far, both problems are unsolved in Rhode Island.

The Committee made a report which the press was pleased to publicize widely. This report presented no new facts but it talked frankly. One of their statements which was sharply criticized in the press at that time has now been verified officially within a few days. The details of all this will be discussed later this evening.

It really looks as though public opinion might now be aroused to the point where in a reasonable length of time oil, chemicals, and liquid feces may be kept out of our formerly healthy and beautiful Bay.

PETER PINEO CHASE, M.D., *Chairman*
EDWARD S. CAMERON, M.D.
ANTHONY V. MIGLIACCIO, M.D.

TUBERCULOSIS

The Committee has had four meetings during the year. The following topics have been the main subjects of discussion:

1. The status of care of tuberculosis in Rhode Island
2. Tuberculosis education
3. Tuberculosis case-finding and control programs in the hospitals of Rhode Island.

There are many problems that militate against the ideal functioning of the State Sanatorium, some of which are beyond immediate control, the chief of which is ap-

continued on page 150



"The sulfonamide drugs given orally are recognized as the most valuable single therapeutic measure

in severe infectious sore throats."

Weille, F. L.: M. Clin. North America 28:1115.

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S.K.F.'s fluid sulfadiazine for oral use . . . is particularly indicated for patients with painfully inflamed throats because:



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Smith, Kline & French Laboratories, Philadelphia, Pa.

ANNUAL REPORTS

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parently economic. This economic problem concerns both patient and hospital personnel. Many patients refuse proper care because adequate support for their families cannot be obtained during the period of enforced rest. Because of the scarcity of trained personnel of all types and the rising wage scale, there is a serious problem in maintaining desired facilities. It is felt that the hospitals for acute diseases in the state could relieve the pressure considerably if they would carefully rule out non-tuberculous disease before requesting transfer to the Wallum Lake Sanatorium. There is also the problem that an appreciable number of patients are by personality not adaptable to institutional care. Family physicians and social workers can be of vast assistance in many cases by familiarizing themselves with the sanatorium and home problems and assisting the patients and their families in meeting them. Frequently, careful explanations and encouragement go a long way in alleviating trying circumstances. More general cooperation of the physicians and patients of the state with the health authorities would greatly facilitate the follow-up of known cases of tuberculosis.

To assist in the education of medical personnel in training in Rhode Island, your Committee sponsors the circulation to the resident staffs of hospitals and to Medical Libraries two pamphlets, "Chest X-ray Interpretation" by J. Burns Amberson, Jr., and "Diagnostic Standards and Classification of Tuberculosis" published by the national society. To further education in regard to tuberculosis in general, a search is being made for a public relations man to work on this phase in Rhode Island.

The plan of the Rhode Island Tuberculosis Association to send copies of "Tuberculosis Abstracts" to the physicians of the state was discussed and approved. This was formerly sent out with the RHODE ISLAND MEDICAL JOURNAL but it became impossible to continue this practice.

The matter of hiring a public relations expert for furthering the work of tuberculosis in the state was discussed with the conclusion drawn that this would be a very valuable move if the proper person were available. The Rhode Island Tuberculosis Association has expressed its willingness to provide a sum of money for the salary of such a man, at least for a trial period.

A survey of case-finding programs for nurses in six hospitals in Rhode Island was presented. It was gratifying to learn that all six hospitals had some form of program, but most of them were inadequate according to present accepted ideals. Only half of them had routine x-rays of students more frequently than annually. Only two mentioned tuberculin tests, and one of these did only annual tests, while the other had tests every four months, on non-reactors. Four of the hospitals stated that graduate nurses were x-rayed annually, whereas in the other two there was no regular routine x-raying during their employment.

Since it is felt that hospitals should be the models for case-finding programs, it was decided that the committee should, at its January meeting, draw up an outline of a satisfactory program. This is to be sent to each hospital in the state with the recommendation that it be followed as closely as possible. In addition to the case-finding programs, recommendations as to tuberculosis control will also be sent.

continued on page 152

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Recent reports in the literature have indicated D.O.D. Deodorizing Capsules efficacious for colostomy odor.

Minnesota Medicine, Aug. 43, vol. 26, p. 709.

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ANNUAL REPORTS

concluded from page 150

Moving pictures were presented depicting the use of photo-fluorographic machines in tuberculosis case-finding. The films were most interesting and instructive. Of particular interest was the ease with which large numbers of people can be handled. It has been found that it is unnecessary for patients to disrobe for the examination, thus saving a great deal of time. With the use of the automatic photo-timer, films of uniform density can be made without measuring the depth of chest. This alleviates the need of highly trained technicians in mass fluorography.

The Committee approved the motion that meetings be held at least four times a year, during the fall, winter, and spring months.

A previous motion that there be at least one talk on tuberculosis on the calendar of the local medical societies each year was again discussed and re-approved.

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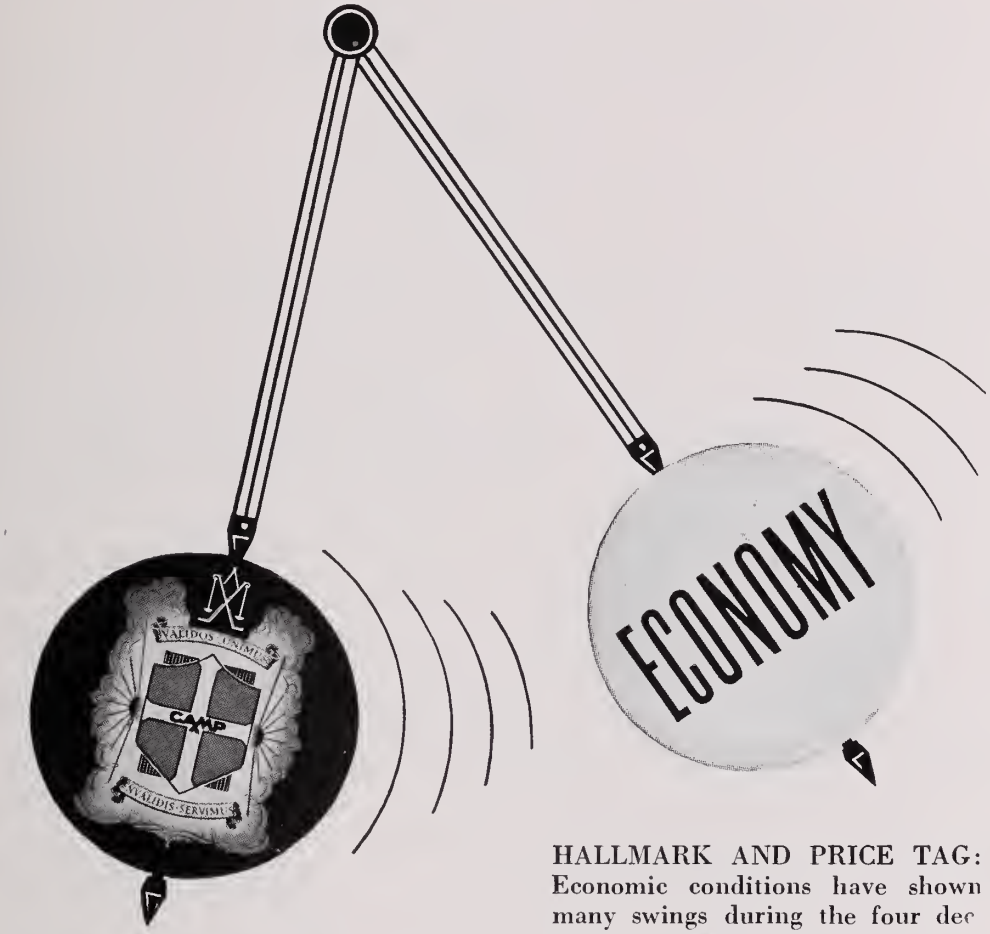
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Certified Milk in Providence during 1946 was obtained from the following farms: Cherry Hill Farm, North Beverly, Mass.; Fairoaks Farm, Lincoln, R. I.; Hampshire Hills Farm, Wilton, N. H.; Walker-Gordon Farm, Charles River, Mass.

Through the courtesy and co-operation of the Boston Commission we have accepted their certification of two farms from Massachusetts and one from New Hampshire.

Bacteriological and chemical examinations of certified milk are made in the laboratories of Brown University under the supervision of Professor Charles Stuart.

All of the herds are under State and Federal supervision and are free from Tuberculosis and Brucella abortus infections.

Much credit is due the management of these farms in keeping the standards of Certified milk on a high plane and these high ideals have been realized in spite of the acute shortages in materials and labor.

It is the hope of the Commission that new and better equipment will be installed during the year, as better materials become available. This will enable the farms to do even better jobs than has been possible the past few years.

During the summer our Commission entertained the Boston Commission and several of our local physicians. Mr. Alfred Cook of the Borden Company of New York gave an interesting talk on the future of Certified Milk.

During December reprints of an article, "Why Certified Milk," written and published by Professor Brown, of Johns Hopkins, was sent to every member of the Providence Medical Association and the Rhode Island Medical Society.

During the past year the Commission has carried one-half page advertisements in the R. I. Medical Journal in an attempt to keep the "Quality Milk" before the medical profession.

The Commission is indebted to Dr. Edwin Knights, Deputy Inspector of Milk in Providence, for his continued interest and advice during the past year.

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MONTHLY AVERAGES OF CERTIFIED MILK FOR 1946

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	Pasteurized			Raw			Pasteurized			Pasteurized			Vit. D. Pasteurized		
	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.
January	3.9	12.50	60	4.2	13.17	2,300			101	4.1	12.90	165	3.7	12.50	84
February	3.7	12.33	85	4.1	13.03	3,457			186	4.1	12.95	498	3.7	12.51	70
March	3.6	12.20	105	4.1	12.89	3,150			380	4.1	12.96	215	3.9	12.55	100
April	3.6	12.16	39	3.9	12.70	3,100	3.7	12.43	713	3.9	12.69	157	3.6	12.36	110
May	3.7	12.19	41	4.0	12.79	4,233	4.1	12.82	400	4.0	12.73	218	3.7	12.46	138
June	3.5	11.97	36	3.7	12.44	4,275	3.3	11.84	469	3.9	12.60	232	3.6	12.10	141
July	3.5	12.01	28	3.8	12.52	2,338	3.5	12.10	687	3.8	12.53	198	3.8	12.38	121
August	3.8	12.30	21	3.6	12.23	3,478	3.6	12.19	151	3.9	12.57	445	3.8	12.40	101
September	4.0	12.43	14	4.2	12.86	3,563	3.8	12.28	256	3.9	12.37	101	4.0	12.53	41
October	3.9	12.27	16	4.1	12.76	4,347	3.8	12.26	90	4.3	12.84	86	4.1	12.79	46
November	3.9	12.24	40	4.1	13.03	12,664	3.7	12.30	128	4.0	12.54	157	4.0	12.64	46
December	3.9	12.45	59	4.1	12.78	5,760	3.8	12.39	88	4.0	12.51	137	4.1	12.64	42
Yearly Average	3.7	12.25	45	3.9	12.76	4,388	3.7	12.29	304	4.0	12.68	217	3.8	12.48	86

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And how are you going to send that kid of yours to college, without the folding stuff?

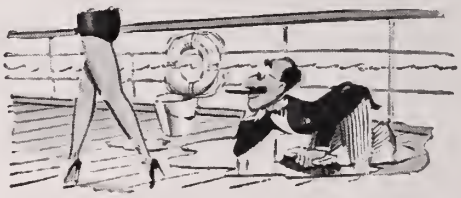
Maybe you think he can work his way through by playing the flute.

If so, you're crazy. (Only three students have ever worked their way through college by playing the flute. And they had to stop eating for four years.)

And how are you going to do that world-traveling you've always wanted to do? Maybe you think you can stoke your way across, or scrub decks. Well, that's no good. I've tried it. It interferes with shipboard romances.

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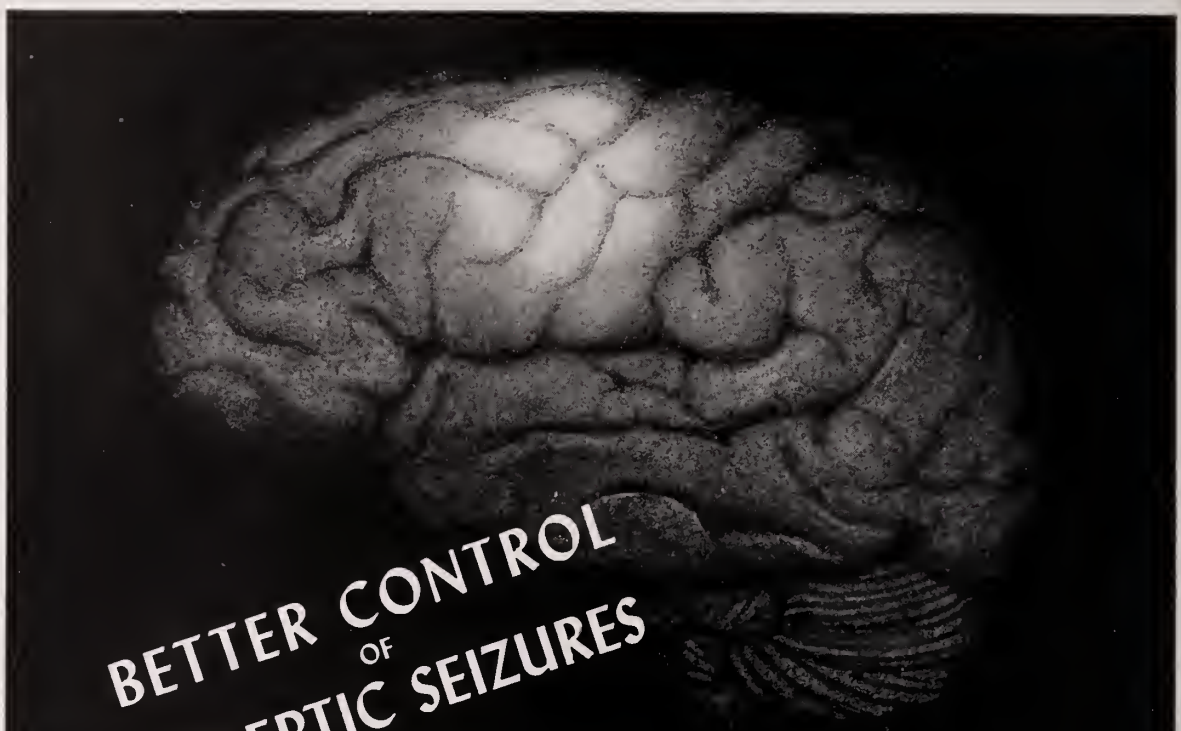
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1. Duncan, G. G.: M. Clin. North America 30:349 (March) 1946.
2. Peters, J. P., and Elman, R.: J.A.M.A. 124:1206 (April 22) 1944.

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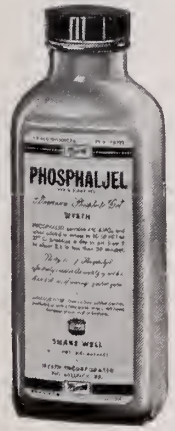
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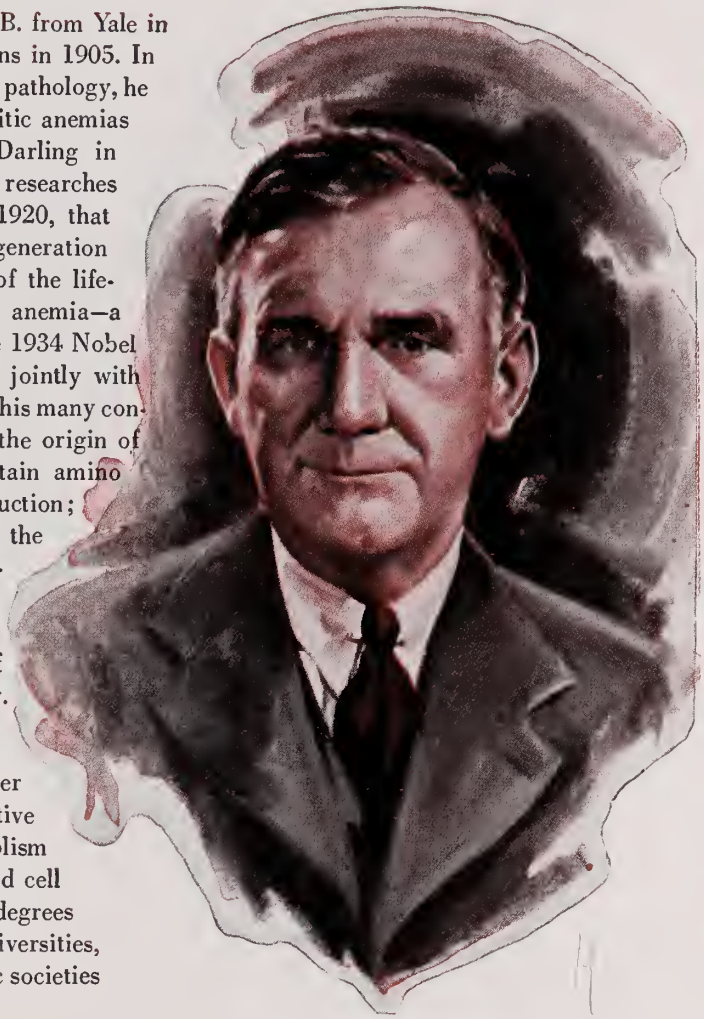
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Dr. Whipple is recognized as a pioneer in the experimental use of radioactive isotopes in the study of the metabolism of hemoglobin, plasma proteins, and cell proteins. He has received honorary degrees from many American and foreign universities, and numerous honors from scientific societies here and abroad.

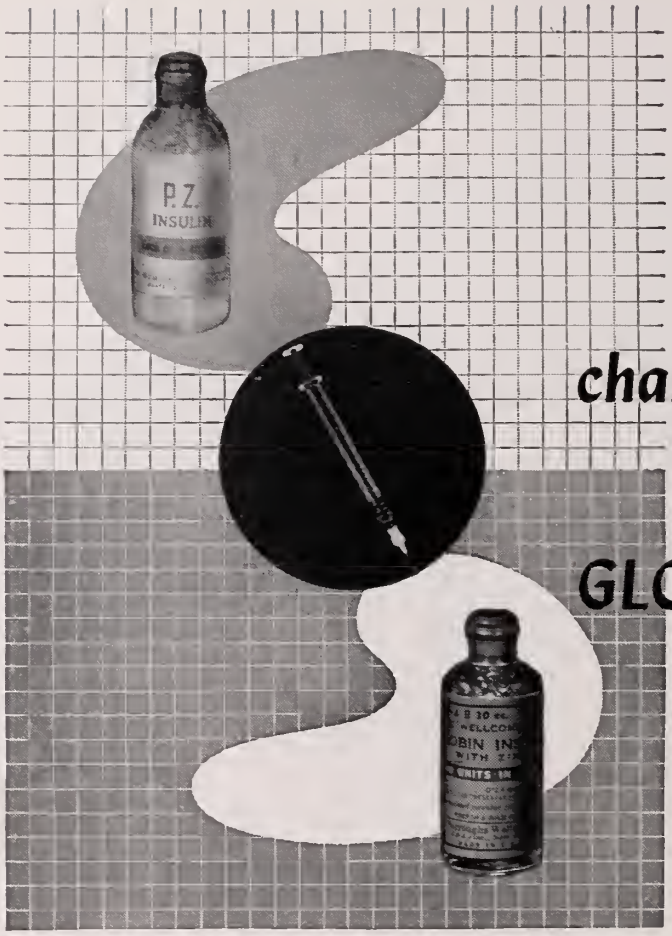


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1. Greene, R. R.: Int. Abst. Surg., 74: 595, 1942

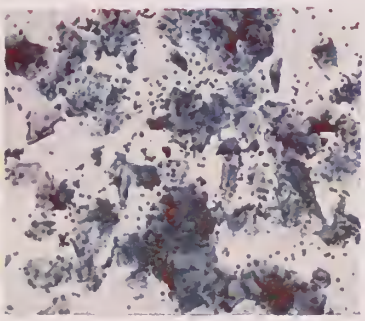
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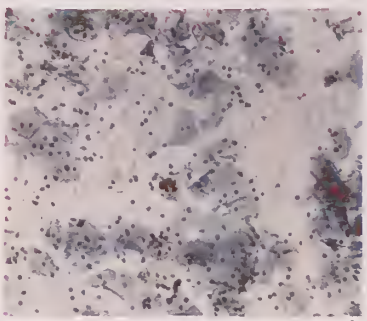
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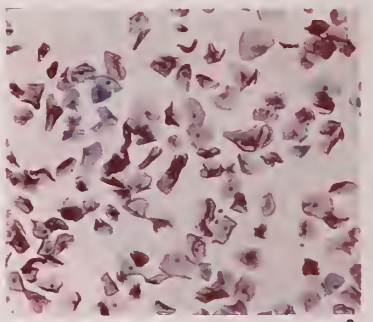
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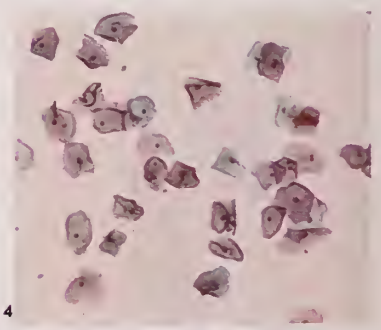
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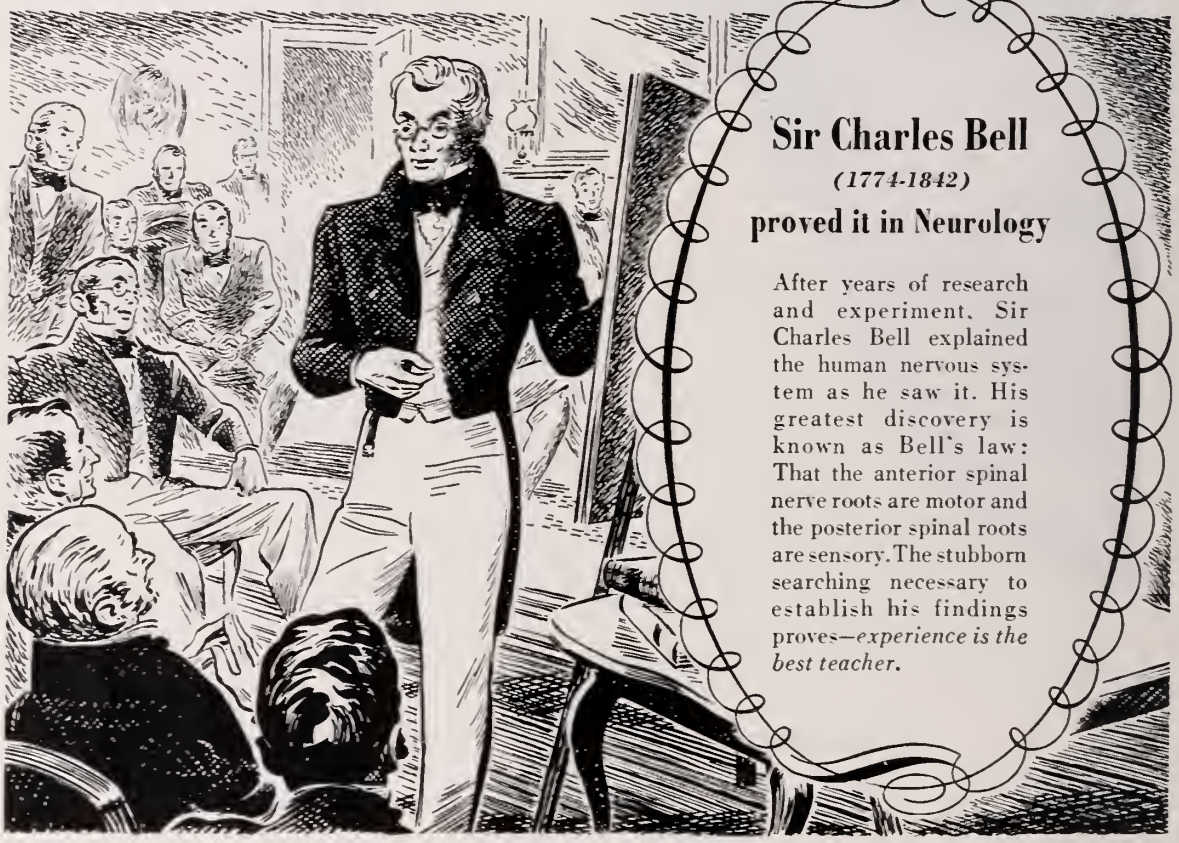
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2. Traeger, C. H., Squires, W. H. and Rudd, E.: Therapeutie Value of Electrically Activated Vaporized Ergosterol, Indust. Med., *14*:202 (March) 1945.

3. Levinthal, D. H. and Logan, C. E.: The Orthopedie and Medical Management of Arthritis, Journal Lancet, *63*:48 (Feb.) 1943.

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Pneumoconiosis

PNEUMOCONIOSIS is particularly prevalent among workers in mines, smelteries, cement plants, and quarries. For years miners had experienced a high incidence of respiratory disorders. It was not until careful medical investigations had been made, however, that the causes were determined and steps taken to prevent recurrences. Pneumoconiosis is today a major problem of medical research. Other industries have their own peculiar hazards. As new materials and processes are introduced into industrial life, new techniques of detection, prevention, and treatment must be developed. This is the task of physicians concerned with industrial medicine. Through their efforts the level of health among industrial workers continues to improve.

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HEART DISEASE AND EMPLOYMENT*

LEONARD J. GOLDWATER, M.D.

The Author. *Leonard J. Goldwater, M.D., Professor of Industrial Hygiene, Columbia University School of Public Health, New York City.*

For the purposes of this evening's discussion I have chosen to consider the question of the employment of cardiacs under five headings. Possibly there are additional aspects which are of interest to the audience. If so, I should be happy to have other topics introduced for discussion at the end of my talk. The five headings I have chosen are:

1. Can cardiacs work?
2. What kind of work can they safely perform?
3. What risks, if any, are involved in the employment of cardiacs?
4. What are the obstacles to the employment of cardiacs?
5. What can or should be done to further the employment of cardiacs?

I shall attempt to provide something approaching a reasonable answer to each of these five questions.

Can Cardiacs Work?

There appears to be ample evidence to prove not only that cardiacs *can* work, but that in fact a majority of them actually *do* work. Several years ago an analysis was made of the work status of 2,081 patients representing the entire enrollment of ten adult cardiac clinics in New York City.[1] Of the total number, which was divided almost evenly between males and females, 65 per cent were found to be doing some form of work and of the 543 who were under 35 years of age, 84 per cent were productively employed. Those in the younger age groups were practically all cases of rheumatic heart disease.

The employed cardiacs represented all types and all degrees of severity of heart disease. As might have been expected, the highest rate of employment was found among those considered to be in Class I, but a substantial number of those in Classes II and III were also employed. (Classes I, II and III refer to classification laid down by the New York Heart Association[2] and represent progressive degrees of physical impairment). The actual percentage of the 2,081 cardiacs who were usefully employed is shown in Table 1.

	MALES			FEMALES		
	Functional Classification			Functional Classification		
Age	I	II	III	I	II	III
O-34	87	73	45	89	86	70
35-54	65	56	21	94	91	83
55 & over	41	29	15	85	81	67
All ages	70	47	18	90	87	73

TABLE I

Percentage, by age, sex, and functional classification, of patients who were working.[1]

It is of interest to note that a larger proportion of females than of males were found to be working, a fact which is related to the number of females who were housewives. This group will be discussed in greater detail presently.

What Kind of Work can Cardiacs Perform?

For purposes of our discussion we shall consider broad occupational classifications rather than specific jobs since to do the latter would lead to excessive detail. Table II gives the occupational classification of the 1,358 cardiac patients who were working.

continued on next page

* Presented at a meeting of the Children's Heart Association of Rhode Island, at Providence, January 21, 1947.

Occupation	PERCENTAGE DISTRIBUTION Male	Female
Professional, clerical and students	29	13
Skilled and semi-skilled	42	6
Unskilled	29	3
Housewives	0	78
TOTAL	100	100

TABLE II

Occupational classification of 1,358 cardiacs.

It is apparent from Table II that cardiacs can carry on a considerable variety of useful occupations. When one considers the fact that housewives ordinarily do the marketing, carry home supplies, cook, clean house and may do laundry work, it is quite reasonable to include them as being employed at a job which often requires a substantial amount of physical exertion. The patients referred to were all performing the type of work indicated and were all being maintained in a state of health sufficiently good to permit them to carry out their respective jobs. It is apparent that the occupational potentialities cover a wide range.

What Risks are Involved in the Employment of Cardiacs?

Possible risks may be considered to be of three types: (a) those to the individual, (b) those to fellow employees or other persons and (c) those to the employer. If it can be shown that a significant risk of any of these three types is entailed it would obviously be illogical to strive for the employment of individuals with heart disease, but if evidence can be adduced to the contrary there is no logical reason for excluding a cardiac from employment. I should like to state at this point, and with all possible emphasis, that in my opinion the worker with unsuspected or unknown heart disease is a far greater menace to himself, his fellow employees and his employer than is the known cardiac. The latter, through selective placement, can be protected against working conditions which might aggravate the heart disease while the former, working without restrictions, may do himself or other irreparable harm.

Any discussion of the employment of cardiacs must include some consideration of the relationship of injury and effort to heart disease and heart failure. It is well known that there are two conflicting schools of thought on this subject. I, myself, would not presume to make anything that even faintly resembles a dogmatic statement on the matter. There are, however, certain relevant points which I think would find general acceptance among cardiologists. In rheumatic heart disease, for example, progression, aggravation and failure occur as a result of new activity of the infection rather than as a result of physical exertion, although obviously heart failure can be precipitated in a person with damaged heart valves as a result of excessive muscular effort. Dr. William D. Stroud, an eminent cardiologist, has gone so far as to urge doctors to permit children, even those having definite valvular damage, "to live happy lives rather than prohibit them from carrying on the activities of youth which give so much happiness."[3]

In arteriosclerotic heart disease with coronary insufficiency there is little doubt that physical effort can intensify the insufficiency and lead to symptoms such as chest pain and shortness of breath and may even lead to acute degenerative changes in the heart muscle and death. There is no evidence, however, that effort per se has any influence in the causation or progression of sclerotic changes in the coronary arteries. Whether or not acute coronary occlusion can be precipitated by physical exertion has for many years been a disputed matter. Using both clinical and statistical approaches, Master[4] has presented strong evidence that there is no relationship between effort and acute coronary occlusion. He found among other things that more than fifty per cent of acute occlusions occurred while the victim was asleep or at rest while only two per cent were associated with unusual exertion. On the other hand Paterson[5] and Boas[6] maintain that coronary occlusion can be brought on as a result of effort. All agree that coronary occlusion occurs only in the presence of pre-existing coronary artery disease.

As far as hypertension and hypertensive heart disease are concerned there is no convincing evidence that effort plays any significant role either in causation or aggravation. In a person with hypertensive heart disease, as well as in the rheumatic or arteriosclerotic cardiac, excessive exertion may precipitate cardiac failure.

The principal risks which an employer may entail in employing cardiacs are: (1) those related to compensation liability, (2) possible damage to property or injury to other employees in the event of a sudden "heart attack" and (3) possible excess absenteeism. These risks lead us to a discussion of the obstacles to the employment of cardiacs.

What are the Obstacles?

Among the most serious obstacles to the employment of cardiacs is the fear on the part of many physicians, all too often transmitted to their patients, that the only safe course for the cardiac is one of complete or almost complete physical rest. (I omit from consideration that large group of individuals in whom the mere presence of a heart murmur has led to a diagnosis of heart disease but actually no heart disease exists. Such persons obviously require no limitation of activity whatso-

ever). The vague, but time honored regimens of "light work" or "sedentary work only" or no "physical exertion" have undoubtedly made premature invalids out of many thousands of cardiacs.

A second major obstacle is found in our workmen's compensation laws. In many states it is common practice to award benefits to the victim (or his widow) of a heart attack if it can be shown that at a time prior to the attack his work required some unusual form of exertion. I have recently studied a number of cases which have been awarded compensation in New York State. In some, an acute coronary occlusion has occurred actually in the course of physical exertion. In such cases it would be most difficult to prove, and even more difficult to convince a compensation referee, that there was no casual relationship. On the other hand there have been cases in which a time interval of several weeks has intervened between the alleged exertion and the attack and the exertion itself was extremely doubtful. Even though one's sympathies may lie with the worker or his family it must be borne in mind that every case which is settled unfairly in favor of the claimant raises a new obstacle to the employment of cardiacs. Employers certainly cannot be blamed for wanting to avoid increased compensation insurance costs which they feel might result if they were to employ persons having heart disease. The absence or inadequacy of "second injury" funds throws potentially increased burdens on the employer who might be interested in hiring cardiacs or other handicapped workers.

Another obstacle, already mentioned above, is the fear on the part of the employer of property damage or injury to other employees in the event of a sudden heart attack. In this connection I believe that the real risk, if any, centers around the employee who is not known to have heart disease rather than around the known cardiac since the latter can be placed at a job in which sudden loss of consciousness would not create any special risk to personnel or to property.

Undoubtedly there are many other obstacles but I should like to mention just one more. I refer to the lack of fundamental research bearing on the various problems which are raised by the employment of cardiacs. Additional knowledge is needed in connection with practically every point which has been mentioned so far and there are many other basic facts which as yet we do not have.

What Can Be Done?

If I thought that the points I have presented created a hopelessly difficult situation or that the obstacles enumerated were insurmountable, I should probably not be here this evening. Actually I believe that much can be done to make the employment of cardiacs safe, logical and desirable. The first, and probably the most important step is education. Physicians must be made to realize that a great majority of cardiacs, when kept under proper supervision, may safely pursue useful occupations and need not be condemned to a life of complete, or almost complete invalidism. The cardiacs themselves (and their families) must be shown that within reasonable limits and under medical supervision a great majority may pursue fairly normal lives. Employers and insurance companies must accept the fact that known cardiacs when placed in suitable jobs do not create any serious additional workmen's compensation burden. The unknown cardiac is a much more serious threat. Employers must also be made aware of the very convincing evidence that absenteeism and labor turnover are less frequent among the handicapped than among physically normal workers.

On the legislative front efforts must be made to bring about enactment of adequate "second injury" funds to remove the possibility of employers being penalized for engaging handicapped persons of all kinds. Uniform workmen's compensation laws and the utilization of impartial medical opinion in the adjudication of claims arising out of heart disease would do much to lower the resistance to the employment of cardiacs.

An essential part of any program is the establishment of facilities for evaluating the occupational potentialities of cardiacs. Many industries engage physicians to perform pre-placement examinations for the purpose of determining whether the physical capacities of an applicant are adequate to meet the physical demands of a particular job.

continued on page 186

"THE HEART'S SONG"

Systole-diastole the whole day through
In a never-ending sequence while you live by what I do
With your life blood passing through me in a cadence like a song
Systole-diastole the whole day long.

Systole-diastole the long night hours
While you rest I still am working though I'm garnering my powers
For the efforts of the morrow, for the travail and the fight
Systole-diastole through all the night.

Systole! Diastole! is it fear or is it rage?
Or perchance it's joy that keeps me knocking 'gainst my bony cage
You can sense my throbbing tumult, or as keen as joy or fear
Systole! Diastole! when your mate is near.

—ALEX M. BURGESS, M.D.

(Reprinted from the R. I. Medical Journal, May, 1927)

RESIDENCY AND FELLOWSHIP PROGRAM AT R. I. HOSPITAL*

Introduction

By Alex M. Burgess, M.D.

Physician-in-Chief, Department of Medicine, Rhode Island Hospital

During the early years of World War II it became evident that with the return of medical officers to civil life there would be a great demand for facilities to enable these physicians to receive further training before their entry into the field of civilian practice. It seemed clear that this would be primarily for the purpose of allowing those men, whose programs had been interrupted, to complete the work that they had left unfinished. It would also give to others, to whom the years of military duty had represented a long separation from the techniques, ideas and ideals of medical work among civilians, an opportunity again to become familiar with such matters under good hospital conditions and critical supervision. When, later on, the so-called "G. I. Bill of Rights" was enacted and was made to apply to returning medical veterans a third group of young men appeared, those who had previously been content to embark on a career of general practice but to whom this governmental aid meant an opportunity, by further study and experience, to qualify themselves as specialists.

As we all know, the American Medical Association, with the aid of other national organizations, took up the matter promptly and efficiently. The resources of the country were marshalled to meet the need. In addition to the so-called "teaching" hospitals (those connected with medical schools) other large institutions, including the Rhode Island Hospital, were urged to plan to increase in every way their facilities for training the returning medical men. This was not an easy thing to do. The Rhode Island Hospital is perhaps a fair example of the way it has been accomplished in this type of institution. It is not our purpose tonight to dwell on the various difficulties that of necessity attended the establishment of such a program. Because of depleted personnel and the demands of war-time practice, these difficulties were great. The credit for success belongs, as in an athletic victory, to the whole team—staff, administration and trustees, who, working together, with a great deal of patience, eventually developed the plan which is now in operation. It *is* our purpose to show you, as best we can, how this plan, which at present involves many departments of the hospital, is accomplishing its purpose in the *Department of Medicine*.

To be of value to the prospective resident the training offered by a hospital must of course be approved by the corresponding National Specialty Board in order to be counted as a part of the requirement of that Board. In the latter part of 1944 such approval was granted to the Rhode Island Hospital in both medicine and surgery and later in pediatrics and in the departments of gynecology and roentgenology it is expected in the near future. There has been an approved residency in cardiology and also in pathology, fractures and anaesthesia at the Rhode Island Hospital for several years. The approval in medicine and surgery followed a survey of the hospital by a representative of the Council on Medical Education and Hospitals of the American Medical Association. It was granted in accordance with the plan to give temporary approval to a number of so-called "non-teaching" hospitals throughout the country and thus to create training opportunities for the large number of applicants that were anticipated.

In the Department of Medicine four residencies, two senior and two junior, have been established. The training of the residents is much as it is in the average large hospital. It involves ward work, conferences, basic science training and clinical research. During 1946 four physicians have occupied these positions and tonight each of them will have a brief word to say to you regarding his work.

In addition to the Residents in the Department of Medicine there is a fifth physician here who will address you. In 1944 the Haffenreffer Family Foundation established a research fellowship in internal medicine at Brown University. This Fellowship was established under the Department of the Medical Sciences of the University and an arrangement was made whereby the work of the Fellow could be carried on at the Rhode Island Hospital in as far as that might be appropriate to his training. The Fellowship was promptly approved by the American Board of Internal Medicine as fulfilling the requirements of the Board. In 1945

*Presented at the 100th Annual Meeting of the Providence Medical Association, at Providence, January 6, 1947

no one was found with the requisite qualifications to fill the position but in 1946 Dr. William J. H. Fischer began his work as the first Haffenreffer Fellow. He has now completed his year's work and will address you briefly this evening.

The work of the holder of the Fellowship differs from that of the residents in that he does not carry any routine responsibilities but is free to plan and carry out investigations in the wards and laboratories and at the same time to participate as a free lance in the rounds, conferences, special clinics and other exercises of the hospital.

Before I introduce to you the individual physicians who during the past year have been the holders of these positions I wish to say that the whole program, ably carried out by these gentlemen, has very greatly raised the tone and standard of the work done in the medical wards, has markedly increased the value of the internes' training and has produced a spirit of interest, enthusiasm and hard work which we can, in the future, never afford to be without. Besides the valuable clinical work accomplished by our residents and our research Fellow may I also call to your attention that each has developed one or more special fields of interest and that already Dr. Fischer and Dr. York have made substantial contributions to medical literature and the other men have work under way that will later be published.

In addressing you this evening each of these men will tell anything he chooses regarding the nature of his work and at least some of them will allude to or exhibit something that may illustrate for you the type of interest that he has developed.

I

STUDIES IN HEPATIC FUNCTION

WILBUR L. MANTER, M.D.

DR. RUSSEL BOWMAN, the biochemist for the Rhode Island Hospital, and I have been doing a comparative study of several liver function tests. An evaluation of these tests as done in our laboratory is being attempted. They have been used in cases of various types, including other than strictly liver disease.

In the course of this work and in reviewing pertinent literature, attention was drawn to the fact that liver dysfunction of sufficient degree to show impairment by function tests occurs in disease states that are not primarily liver disease. This in spite of the well-known fact that considerable disturbance of liver function usually exists before it is detected by available laboratory tests. The versatile and important functions that the liver plays in body metabolism would seem to make it worthwhile to consider it more often in disease, medical and surgical, particularly as nutritional therapy is now so much better understood. For instance, protein regeneration, so important in severe acute or any chronic disease, depends largely on the ability of the liver to utilize the building blocks supplied it.

As an example of a recognized pathologic entity that may frequently occur secondary to other disease, so-called fatty liver may be mentioned. This condition is known to result from many causes, including inadequate or abnormal dietary intake, various infectious diseases, poisons, conditions associated with anoxia, diabetes, pregnancy and thyrotoxicosis. In thyrotoxicosis, for example, figures from various autopsy series have shown on an average close to 90% of fatty livers, and in untreated thyroid cases, the incidence of cirrhosis is known to be high. Ravdin, et al., at the University of Pennsylvania, found that approximately 29% of their patients with longstanding gall bladder disease had abnormally high amounts of lipid present in the liver. In a comparative study that they did selecting patients with serious impairment of biliary function, they found that pre-operative treatment with special diet reduced the fatty acid content of the liver at the time of operation to the near normal mean value of 4 grams %, as opposed to the high mean value of 14.4 grams % in the controls.

It has been pointed out that seriously ill surgical patients frequently show subnormal liver function due to malnutrition, or to the effect of the disease itself, particularly biliary, thyroid or longstanding gastro-intestinal disease. These patients with impaired liver function withstand surgical trauma and anesthesia less well and have more post-operative complications. Casten, et al., found impaired liver function as measured by the relatively sensitive hippuric acid excretion test in 48 of 62 chronically and severely ill surgical patients. All or 100% of these 48, as contrasted with 50% of those with the negative tests, showed a definite and usually prolonged post-operative drop in plasma protein. This in spite of better pre-operative preparation of the patients with the abnormal liver function tests.

It might incidentally be added that in our series a patient after diabetic coma, two with severe thyrotoxicoxis, and three acutely ill with trichinosis all had positive cephalin flocculation tests. Perhaps positive tests of this sort in patients presumably without primary liver disease cannot always be considered as false positives.

continued on next page

II

MEDITERRANEAN OR COOLEY'S ANEMIA

A Case Report

HERBERT F. HAGER, M.D.

IN ADDITION to my principal duties on the wards I had the opportunity to study the severe form of Mediterranean or Cooley's Anemia in a 20-year old Portuguese youth and the mild form of the disease in other members of his family. The results of the studies are being prepared for future publication, but certain of the features of the disease in this family will be outlined.

The parents of the patient noticed shortly after birth that he had a peculiar yellowish pallor to his skin and that the left side of his abdomen was larger and firmer than the right. At times it was noticed that the sclerae of his eyes took on a slight yellowish tinge.

At fourteen years of age he was admitted to St. Joseph's Hospital where the color of his skin and the presence of a large spleen was noted. His blood studies there revealed a RBC of 2,670,000, a Hb. of 5.6 Gm/100 c.c., 12% reticulocytes, and the blood smear showed marked anisocytosis and poikilocytosis, stippled cells and 9 nucleated RBC/100 WBC. The fragility test showed a slightly increased resistance to hypotonic saline solutions. X-ray films revealed that the bones of the pelvis, spine and upper femora had marked decalcification and thinning of the cortical bone with marked irregular trabecular markings. A splenectomy was performed and several transfusions were given.

He was first seen at the Rhode Island Hospital last summer when he was admitted because of pneumonia and the present studies were begun.

Now, at 20½ years of age he shows nearly all the classical findings associated with the severe form of erythroblastic anemia or thalassemia major. The members of his family were studied and both parents and one sister show the hematological findings of thalassemia minor. Some of the findings are illustrated in the table below.

As the presentations this evening are designed primarily to illustrate the residency program of medical education at the Rhode Island Hospital this case may be used to illustrate the various methods utilized to study patients and their diseases. The first approach from the clinical point of view is: what disease or diseases does a patient have and what can be done to help him. Then the so-called "vertical approach" may be applied whereby a disease entity such as pneumococcal pneumonia, luetic heart disease, or Cooley's erythroblastic anemia may be studied in its entirety. In the present case that meant the study of the disease in two generations of the same family. The "horizonal approach" is also invaluable. The function of one organ, the application of a series of tests, or the effect of a particular form of therapy is applied to a number of people with various diseases, and the results studied and correlated. In illustration of the latter type of approach we have the liver function studies, and the plasma studies as outlined by the other resident physicians. It is of interest to note that in the application of the vertical and horizontal approaches the paths of study frequently converge at the same patient.

Age	Normal Adults	Father M.S. 53	Mother M.S. 52	Sister MR 21	Sister LS 22	Sister F.S. 13	Patient M.S. 20
Ab	13—16	15.0	14.0	11.0	11.0	13.7	5.8
RBC	4.5—5.0	6.19	4.98	3.89	4.0	4.45	2.9
Hem.	36—54	45.5	41.0	33.5	35.5	38.2	24.8
C.I.	0.9—1.1	0.83	0.96	0.97	0.95	1.06	0.64
MCH	27—32	24.2	28.1	28.2	27.5	30.7	20.0
MCV	80—94	73.5	82.3	86.1	88.7	85.8	85.5
MCHC	33—38	32.9	34.1	32.8	30.9	35.9	23.4
WBC	5—10	13.2	9.2	10.9	6.55	9.4	28.0
N-RBC	0	0	0	0	0	0	200
I.I.	3—8	10.2	4.6	2.5	6.0	<11.0	10.26
A.	0	+	+	+	+	0	+++
P.	0	+	+	+	0	0	+++
T. Cells	?	+++	++	+	0	0	+++
Rh	—	+	+	+	+	+	+
H. Began	0.45	0.40	0.35	0.35	0.40	0.40	0.30
H. Completed	0.30	0.25	0.25	0.25	0.30	0.30	0.05

A COMPARISON of the VOLUMES OF BLOOD, PLASMA, and CIRCULATING CELLS in SECONDARY POLYCYTHEMIA and in SEVERE ANEMIA

WILLIAM J. H. FISCHER, JR., M.D.

THE purpose of this report is to present briefly and in graphic form the contrasting states of the volume of the circulation in a case of secondary polycythemia and in a case of severe anemia. It is not within the scope of this paper to discuss the aspects of the pathological physiology of the two conditions described.

Materials and Methods

Patient J. S. (Figure I) is a 22 year old male. Born a "blue baby" he has been followed in the Clinics and Wards of the Rhode Island Hospital for many years. There is reasonable clinical and roentgenological evidence that this patient has the congenital cardiac syndrome known as the Tetralogy of Fallot.

Patient I. S. (Figure I) was admitted to the Rhode Island Hospital with a profound anemia.

FIGURE I

DATA	J. S. 22 WM		I. S. 30 WF	
Diagnosis	Tet. Fallot		Ref. Anemia	
Wt.—Kgs.	47.3		45.4	
Values	Predicted	Determined	Predicted	Determined
Blood Volume—c.c.	4,025	13,310	3,865	3,325
Plasma Volume—c.c.	2,125	2,675	2,045	3,120
Cell Volume—c.c.	1,900	10,635	1,820	205
Hematocrit—%	47	80	42	6.2
Hemoglobin—GMS %	16	23.1	14	2.5
Red Cells—C.M.M.	5.3	7.1	4.8	0.62

It was an illness of long standing and had not responded to prolonged liver and iron therapy. In spite of hospital treatment with whole blood and further antianemic therapy the patient's course was rapidly downhill and she expired within two weeks after admission. The clinical diagnosis was Refractory Anemia.

The volumes of blood, plasma and circulating cells of both of these patients were studied by the method of Gregersen[1] and Noble & Gregersen[2] with the dye T-1824*. The predictions of normal values of blood volume were according to Gregersen.[1] The normal values for hematocrit, hemoglobin and red cell count are taken from Wintrobe.[3] The determined values for hematocrit, hemoglobin and red cell count were obtained by standard laboratory methods.

*Supplied by the William R. Warner Co., N. Y., N. Y.

Results and Discussion

The results of these studies are tabulated in Figure I.

Worthy of note is the fact that in J. S. the enormous blood volume is almost entirely accounted for by the increase in circulating cells. Confirmatory of these absolute figures are the distinctly abnormal hematocrit, hemoglobin and red cell values.

In contrast, in I. S., the blood volume is slightly lower than normal but is almost entirely accounted for by plasma, the cell volume being extremely low. Again the relative values of hematocrit, hemoglobin and red cells are on the same order.

Summary

The contrasting data on the volume of the circulation in a case of secondary polycythemia and in a case of severe anemia are presented briefly.

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III

CHARLES L. YORK, M.D., AND MICHAEL DIMAIO, M.D.

Due to the fact that Dr. Charles L. York and Michael DiMaio had their detailed reports accepted for publication elsewhere, their presentations at the Providence Medical Association meeting cannot be printed at this time.

Doctor York, reporting "A Study of the Origin of a Case of Homologous Hepatitis" presented a study involved the epidemiology of an icterogenic

continued on next page

agent contaminating a pool of plasma. His report is summarized as follows:

On June 4, 1946, a patient was admitted with a perforated gastric ulcer which was repaired surgically and whose convalescence was extremely stormy. Blood and blood products given totaled six 500 c.c. units of plasma and twelve 500 c.c. blood transfusions.

The patient was readmitted on August 30, 1946, and expired in four days from diffuse hepatitis.

There had been fifty-nine donors to the plasma pools used in this case and the twelve blood donors. These were contacted by mail and requested to fill out and return a simple questionnaire asking if they had had jaundice at any time up to six months after donating their blood. Answers were received from fifty-six of these seventy-one donors. Only one answered affirmatively. This donor experienced characteristic "Infectious Hepatitis" three weeks after donating blood. The pool to which that plasma became a part was given to thirty other patients, only one of which survived the immediate disease for which the plasma was given as a therapeutic measure. The lone surviving patient did not develop hepatitis.

The time interval between the administration of the suspected icterogenic plasma and the development of hepatitis was approximately eighty days, a period consistent with the incubation period attributed to homologous serum hepatitis.

* * *

Doctor DiMaio's presentation of *"Hepatic Function in Cardiac Disease"* was a study giving evidence of decreased hepatic function as measured by several standard tests in patients with cardiac failure, and showed progressive improvement as the evidences of failure disappeared.

HEART DISEASE AND EMPLOYMENT

continued from page 181

The fact that such examinations may in some instances be used for other purposes is not sufficient reason for general condemnation of the procedure. The principle of selective placement should also be applied in vocational schools so that cardiac children are trained in trades which are compatible with their physical capacities. The estimation of physical capacities in relation to the demands of a job may also be done by voluntary health agencies such as the Children's Heart Association of Rhode Island as a service to the State Employment Service and to employers. Naturally such a program would require a certain amount of financial support.

Finally, there is the need for research: not the kind that is done in laboratories with guinea pigs and test tubes and special testing gadgets, but simple observation of the cardiac in the course of his or her daily routine. Further information is needed on two simple points: (1) what types of occupation are best suited to persons with heart disease and (2) what effects, if any, do various occupations have on the course of heart disease? To obtain these basic data no elaborate experimental apparatus is required but merely a means for carefully following the cardiac and keeping full records on his health in relation to his occupational status.

The importance of developing an adequate program for the employment of cardiacs can scarcely be overestimated. It has been estimated that there are at least 8,000,000 persons in the United States who have some form of heart disease.[7] With the progressive aging of the population this number can be expected to increase. If this large segment of our population is to be considered unemployable the social and economic implications are staggering. Fortunately we know that most cardiacs can work so that the problem is one of finding suitable employment for them and providing them with medical supervision so that they may continue at their jobs. The interest and activities of the Children's Heart Association certainly constitute a step in the right direction.

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CARE OF POST-OPERATIVE, CARDIAC AND ELDERLY PATIENTS

Bayview Convalescent Home

ELIZABETH A. SANTOS

57 Stokes St. Conimicut, Rhode Island

BAYVIEW 1092-R

A CASE OF CORNEAL ULCER TREATED WITH PENICILLIN SOLUTION

ROBERT R. CHACE, M.D.

The Author, *Robert R. Chace, M.D., of New York, Assistant Ophthalmologist, Presbyterian Hospital and Vanderbilt Clinic, New York City.*

F. G., a thirty-nine year old married, white male, a clerk, gave the following history. Nine days previously he had sustained a finger nail scratch of the cornea of the left eye. He was treated in a hospital emergency room and then consulted a private physician who gave him drops for the eye and an intravenous typhoid injection. The patient stated that he had a mild febrile response to this, followed by a spiking temperature to 104 degrees Fahrenheit on three successive days. He also received a sulfa drug by mouth which upset his stomach and, in addition, he used sulfa ointment locally in the eye. The eye became more irritable and painful and he consulted another physician who cauterized the ulcer with acid on two occasions. As the eye became worse, he sought further care.

When seen by me the eye was extremely painful and the patient could get relief only from the instillation of four percent cocaine solution every thirty minutes. He was in a state of extreme fatigue and near collapse. Vision in the right eye was 20/30+ and in the left 20/200. Examination showed the right eye to be normal. The left eye showed marked edema of the lids and extreme blepharospasm. The bulbar conjunctiva was chemotic and injected. The cornea was hazy and there was a large, fairly deep ulcer to the temporal side of and slightly below the pupillary area of the cornea. The ulcer was filled with necrotic material and was surrounded by an area of infiltrate roughly five by three millimeters in area. The lower portion of the infiltrate was quite white and suggested a clumping of leucocytes when viewed by the corneal microscope. Tension was normal to fingers. The patient was admitted to the Institute of Ophthalmology and given sedatives. A solution of atropine one per cent was instilled and hot compresses were given. Because of a gall bladder condition and because of unpleasant effects of previous chemotherapy, local treatment seemed indicated. An ointment of five per cent penicillin was used locally, but this seemed to irritate the eye. Therefore, treatment was changed to a two and one quarter per cent solution of penicillin in saline. This contained one thousand Oxford units. The solution was instilled hourly for the first twenty-four hours and the eye was covered with a light dressing. The solution was given every two hours after the first day and the patient noted a marked relief in forty-eight hours.

Cultures from the ulcer and from the conjunctiva showed only a few colonies of staphylococcus albus. Ten days after the treatment was started, the cornea ceased to stain with fluorescein. The patient was discharged on the seventeenth hospital day. At that time vision was 20/30 in the affected eye and there was a decrease in the area of infiltration.

The fact that the eye was over treated before being seen at the Eye Institute may complicate the picture. However, the relief of pain and the rapid healing of the ulcer was quite definite.

The case is presented as one in which a "continuous drip" treatment with penicillin solution was used for the relief of a stubborn ulcer of the cornea.

INDUSTRIAL PHYSICIANS ELECT

At the annual meeting of the Rhode Island Society of Industrial Physicians and Surgeons, Inc., held at Collyer Insulated Wire Company, Pawtucket, Rhode Island, February 4, 1947, Frank A. Merlino, M.D., Chairman of the Nominating Committee, presented the following slate of officers for the current year, and they were duly elected to the respective offices:

Richard F. McCoart, M.D., *President*
Thomas A. Egan, M.D., *Vice President*
James P. Deery, M.D., *Secretary*
Robert T. Henry, M.D., *Treasurer*

The Board of Directors as follows:
Remington P. Capwell, M.D.
Edward F. Dougherty, Jr., M.D.
Charles L. Farrell, M.D.
Joseph C. Johnston, M.D.

TUBERCULOSIS CASE FINDING AND CONTROL IN HOSPITAL PERSONNEL

A Special Report by the Committees on Tuberculosis of the Rhode Island Medical Society and the Providence Medical Association which has been approved by the House of Delegates of the Rhode Island Medical Society.

THE incidence of tuberculosis in nurses and internes is known to be high, in some instances as high as ten per cent.

A few simple procedures, if faithfully carried out, will greatly diminish the likelihood of tuberculosis in these groups.

A recent survey of the case-finding methods in the hospitals of Rhode Island shows lack of uniformity in this regard.

Therefore, the Committee on Tuberculosis of the Rhode Island Medical Society and the Providence Medical Association have drawn up recommendations in an attempt to reduce to a minimum the incidence of tuberculosis in our hospital personnel. If tuberculosis is to be conquered, and it can be conquered, hospitals and their staffs should be the ones to show the way.

A program is of little value unless there is eternal vigilance to see that it is properly carried out. In a hospital of moderate size, this can ordinarily be done by appointing responsible members from various departments to work under a physician in over-all charge. The duty of each member is to see to it that the program is carried out in his or her department. As an example, a member of the hospital superintendent's office should be responsible for the internes and residents, one from the nursing superintendent's office for the nurses, and one from the personnel director's office, or a nurse specifically assigned, for the non-professional personnel. The program should be prescribed and enforced, not voluntary. If voluntary, it is sure to fail.

The physician in charge should make out the program adaptable to his particular hospital, should oversee the case-finding work, including the keeping of records, and decide on the disposition of whatever cases may be found.

The program is divided into two parts—I. Case-finding in the hospital personnel. II. Control of tuberculosis throughout the hospital.

I. *Recommendations for Tuberculosis Case Finding.* (All Mantoux texts should be done first with first test dose P.P.D.—0.00002 mg. and, if negative in forty-eight hours, be repeated with second test dose—0.005 mg.)

A. Visiting Physicians—chest plate or photofluorograph annually.

B. Internes and Residents—x-ray on admission and Mantoux unless previously positive.

   a. Non-reactors to Mantoux—repeat Mantoux tests on all non-reactors every four months. X-ray immediately when they become reactors and every four months for a year, thereafter every six months.

   2. Reactors—x-ray or photofluorograph every six months and on completion of service.

C. Nurses.

   1. Student nurses—chest plate or photofluorograph on entrance and on graduation and Mantoux test on entrance.

      a. Non-reactors to Mantoux—repeat Mantoux tests on all non-reactors every four months. X-ray immediately when they become reactors and every four months for a year, thereafter every six months.

      b. Reactors to Mantoux—x-ray every six months.

   2. Graduate Nurses—under thirty years of age—initial chest plate or photofluorograph and repeat every six months and on completion of service.

   3. Graduate nurses—over thirty years of age—initial chest plate or photofluorograph and repeat every year and on completion of service.

D. Employees.

   1. Food handlers and those coming in close contact with patients, e.g., ward maids, orderlies, technicians, social service workers, etc., if under thirty—initial chest plate or photofluorograph and repeat every six months and on completion of service.

   2. All others—initial chest plate and repeat annually and on completion of service.

The above is presented in chart form as follows:

	CHEST PLATE OR PHOTOFLUOROGRAPH				Mantoux
	At start and at completion of service	Every 4 months	Every 6 months	Every 12 months	Every 4 months
Visiting Physicians	xx			xx	
Internes and Residents (a) Non-Reactors	xx	xx for 1 yr. after becoming reactors			xx
(b) Reactors	xx		xx		
Student Nurses (a) Non-Reactors	xx	xx for 1 yr. after becoming reactors			xx
(b) Reactors	xx		xx		
Graduate Nurses (a) Under 30 years	xx		xx		
(b) Over 30 years	xx			xx	
Employees (a) Close patient contact and under 30	xx		xx		
(b) All others	xx			xx	

11. *Recommendations for Tuberculosis Control.*

To prevent contraction of tuberculosis in hospital personnel certain precautionary measures are advisable.

The most effective method of preventing tuberculosis is to avoid contact with open tuberculosis.

The unsuspected case is more dangerous than the suspected.

Routine x-raying or photofluorographing is is the only effective practical mass method of converting the unsuspected into the suspected case.

A non-reactor to the Mantoux test is in more serious danger when subjected to massive exposure than is the reactor.

Therefore, your Committee recommends:

1. Routine chest plate for all hospital admissions.
2. Prompt barrier technique for all suspected cases until proven nontuberculous.
3. Mantoux-negative nurses and internes not to be permitted to care for open cases of tuberculosis.

The use of BCG is under consideration, but a definite policy has not been formulated as yet.

The Committee would be glad to have any criticisms of these recommendations and would be glad to give any assistance they can in setting up a specific program to meet the requirements of an individual hospital.

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Check the dates NOW . . .

MAY 14 and 15

ANNUAL MEETING . . . R. I. MEDICAL SOCIETY

SECTIONAL MEETING OF AMERICAN COLLEGE OF SURGEONS

At PROVIDENCE — March 28-29

THE fourth of a series of seven Sectional Meetings of the American College of Surgeons will be held in Providence on March 28 and 29, with headquarters at the Providence-Biltmore Hotel, according to an announcement by Dr. Irvin Abell of Louisville, President and Chairman of the Board of Regents. Rhode Island and surrounding states will participate. The preceding three Sectional Meetings will be held in Baltimore, March 10-11; in Omaha, March 14-15; and Fort Worth, March 20-21. Later meetings will be held in San Francisco, April 7-8; Vancouver, April 21-22; and Winnipeg, April 28-29.

Opening Friday morning, March 28, at 8:30 o'clock, and continuing through Saturday afternoon, March 29, at the Providence-Biltmore Hotel, Providence, will be the Sectional Meeting embracing the entire northeastern region of the United States. Surgeons, members of the medical profession at large, medical students, and hospital representatives from this area, are invited to attend the sessions, which will begin each morning with the showing of medical motion pictures, followed by separate sessions for the medical and hospital delegates.

The scientific session for the first morning will include the following talks: Surgery of Malignant Growths in the Neck—Dr. William F. MacFee of New York; Advances in Anesthesia—Dr. Ralph M. Tovall of Hartford; Surgery of Carcinoma of the Bladder—Dr. Samuel N. Vose of Boston; and Vascular Surgery—Dr. Harris B. Shumacker, Jr., of New Haven.

Luncheons for physicians, surgeons, and hospital representatives followed by discussion of subjects covered at the morning sessions will be held on both days.

Two panel discussions will feature the scientific sessions on the first afternoon. The first, on fractures, will be conducted by Dr. Robert M. Yergason of Hartford, with Dr. Mather Cleveland of New York and other prominent authorities on fractures serving as collaborators. The other panel will be on intestinal obstruction, and will be conducted by Dr. Arthur W. Allen of Boston.

A dinner will be held on the evening of the first day, followed by a premiere showing of a medical motion picture now under production, and concluding with a reception.

Speakers at the scientific session on the second morning will be Dr. Frank L. Meleney, New York, on "Use of Antibiotics in Surgical Practice"; Dr. Francis D. Moore, Boston, on "Surgery of Malignant Growths of the Neck"; Dr. Arthur H. Blakemore, New York, on "Treatment of Portal Hypertension"; and Dr. Frank E. Adair, New York, on "Management of Cancer of the Breast."

The scientific session program for the second afternoon will consist of panel discussions on postoperative care and on carcinoma of the colon. The moderator of the first panel will be Dr. John H. Mulholland, New York; the collaborators will be Dr. James B. Blodgett of Boston, Dr. Bliss B. Clark of New Britain, and Dr. E. A. Rovenstine of New York. The moderator of the second panel will be Dr. Samuel C. Harvey of New Haven; the collaborators will be Dr. Arthur W. Allen and Dr. Richard B. Cattell of Boston.

LOCAL COMMITTEE FOR SURGICAL MEETING

The local committee on arrangements for the Section meeting of the American College of Surgeons to be held here the end of March is headed by Dr. William P. Davis, chief of the surgical staff at Rhode Island hospital. His committee includes the following: Dr. Herman C. Pitts, Dr. Jesse P. Eddy, 3rd, Dr. Albert H. Jackvony, Dr. Henry B. Moor, Dr. Robert H. Whitmarsh, Dr. Guy W. Wells, and Mr. Oliver G. Pratt, superintendent of R. I. Hospital, all of Providence; Dr. John E. Ruisi of Westerly, Dr. Robert T. Henry of Pawtucket, and Dr. John P. Jones of Wakefield.

ELECTED BY COLLEGE OF SURGEONS

At the convocation of the American College of Surgeons held on December 20 during the clinical congress at Cleveland the following Rhode Island physicians were elected to fellowship: James H. Bartley, M.D., Francis H. Beckett, M.D., Ezio J. Bernasconi, M.D., David Freedman, M.D., Waldo O. Hoey, M.D., Israel Kapnick, M.D., James R. McKendry, M.D., and Ernest D. Thompson, M.D., all of Providence, and John H. Gordon, M.D., of Pawtucket.

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WHY NOT PRIVATE INSURANCE?

In the discussion in recent months of plans for low cost insurance programs to provide medical and surgical care there has been little consideration given to the possibility of utilizing private insurance carriers. Emphasis has been placed so heavily on the non-profit organization that one would almost think that the good old American system of regulated free enterprise that made this country the great nation it is should be scrapped. What's wrong with private insurance? If it can satisfy the people the length and breadth of this nation in meeting their needs for life, fire, automobile, and health and accident insurance, why can't it be explored further for possible coverage in the so-called social insurance field of group medical, surgical and hospital care?

The Connecticut State Medical Society, faced with a serious problem when the Connecticut Blue Cross declined to act as the agent to market contracts for prepaid medical insurance in behalf of the proposed Connecticut Plan for Medical Care, has turned to the private insurance carriers for help. One meeting has been held, and others are to follow. In reaching its decision the Connecticut Society was not prompted merely by the fact that its State houses the home offices of some of the major insurance companies. On the contrary the Society has done some worthwhile thinking on the matter, and in the report of its Committee, adopted by its House of Delegates on December 30, it states

> "We are convinced that a successfully operated plan for medical insurance is not within the capabilities of amateurs, but rather calls for the knowledge and experience of professionals. In other words, we believe that insurance should be written by insurance companies."

And commenting on the uncertainty of a service type of program (as was demanded by the Blue Cross of Rhode Island if it were to accept our plan) the Connecticut Society stated

> "We have observed the effects of the depreciation in purchasing power of the dollar which goes under the name of inflation, and the disturbing effects these changes have on plans of the service type. We are convinced that premiums collected as dollars should be paid out in benefits as dollars, not as guaranteed service.
> "The consequences of this conclusion are far-reaching. They vastly simplify the problem of administration. It follows that there will be no need for setting a level of income to determine

continued on next page

the method of payment of benefits. All the difficulties of furnishing guaranteed service instead of a cash payment are eliminated. Patients and physicians will continue to arrange the fee by mutual agreement.

"Connecticut people at the present time are widely enjoying the benefits of this type of protection against medical and hospital expense. Over 10% of our population is so covered. These contracts have given general satisfaction alike to the patient, the physician, the employer, and the hospital."

Should this type of insurance be extended? Connecticut is strongly of the opinion it should, and its House of Delegates supported the belief

". . . that this type of insurance should be extended to cover catastrophic illness for more and more of the population, and furthermore that the extent of the benefits should be broadened step by step to cover medical as well as obstetrical and surgical illness. Various insurance companies licensed to operate in Connecticut already write insurance which we believe to be of great social usefulness, but many more persons can be covered and it is certain that the medical profession can assist greatly in increasing the sale of these contracts. We believe that the contracts offer dependable coverage and return a substantial amount of the premium dollar as benefits and that they can be made even better."

That such thinking as this can be projected into realistic action has been demonstrated in Wisconsin where the State Medical Society initiated a year ago the now widely-known "Wisconsin Plan". This program, utilizing the services of twenty-four private insurance companies, offers the people of that state a broad, low-cost surgical, obstetrical and hospital insurance service that sold better than 46,000 contracts in its first year of operation. The plan is written on both a group and individual policy basis and both employes and their dependents may be covered.

The criticism of proponents of non-profit insurance plans that this type of program does not meet the low income group has been adequately answered in Wisconsin where participating physicians have signed an agreement with the State Medical Society that their charges for operations will not exceed the benefits provided in the insurance policy for all insured people without dependents whose yearly income does not exceed $2,080, and for those with dependents whose yearly income does not exceed $2,600. For persons in higher income brackets the plan offers indemnity up to the amounts specified in the policy.

Thus, through private insurance, Wisconsin offers the same service to the people of that state that the Rhode Island Medical Society surgical insurance program would offer people here, with the exception that the annual income for the subscriber with dependents here would be set at a $2,500 family income limit.

One other observation must be noted in the Wisconsin plan. The private insurance companies' policies including hospitalization insurance are approved. In other words, the Blue Cross non-profit plan faces competition from private insurance with support from the medical profession. But this is a healthy situation, for without competition any program tends to become monopolistic. We have seen that happen here in Rhode Island as regards the Cash Sickness Compensation plan which has forced private group disability insurance plans out of the competitive picture.

Blue Cross hospitalization insurance has done a grand job, and it has filled a long-felt need. But it must not be glorified with an evangelical enthusiasm that hides the fact that it can become a monopoly, against which we must all be constantly on guard. Blue Cross, in spite of its non-profit status, is a part of the general insurance industry and as such it has the obligation to serve the best interests of the people with due regard for regulated free enterprise. To act otherwise will be to take the first steps that eventually lead to socialization.

THE WOMAN'S AUXILIARY

Perhaps it is the heritage of the independence first fostered in these colonies in New England. Perhaps it is the conservatism, or some similar fault or virtue, depending upon personal points of view, that has influenced us. At any rate, Rhode Island is one of the five last states to recognize the Woman's Auxiliary to the State Medical Society. Our neighbors in Connecticut accepted the need for an Auxiliary a year ago, while New Hampshire has had such an organization for years. We, together with Maine, Vermont, and Massachusetts continued to stand aloof.

Now that an Auxiliary has been organized, and we have had the opportunity to consider carefully its objects we wonder that we have allowed ourselves to continue for such a long time without the collective help of our wives whose influence on our individual lives and careers is historic. We are glad that our wives have accepted the opportunity now to band together to extend the aims of the medical profession to all organizations that look to the advancement of health and health education. We sincerely hope also that through the Auxiliary there will be cultivated friendly relations and mutual understanding among physicians' families for there is no group in the community whose home life suffers more from the demands made by the public.

In Mrs. Herbert E. Harris, already a successful leader in civic clubs, in addition to being an outstanding wife and mother, the Auxiliary has a president who will certainly get the new organization off to a good start. We shall all look forward with interest to the development of the State Auxiliary, as well as District Auxiliaries, and to the promotion of their activities in the furtherance of better health for the people of Rhode Island.

WHAT HAS OSTEOPATHY CONTRIBUTED?

Some years ago a Providence surgeon was crossing the United States by train. At a midwestern stop he got out to stretch his legs. At the end of the platform he saw a woman in a buggy with a horse refusing to cross the tracks. He seized the reins, led the horse across the tracks and looking around saw his train leaving and beyond his reach. He had twenty-four hours to wait for the next train westward, and his trials during that time are too painful to tell here.

Recently a group of Providence physicians moved by similar altruistic motives have attempted to aid those in trouble, and in this case, as in the case of our other surgical associate, the good Samaritans are suffering for their intentions. Let us consider their motives and actions. They want to help those in need of surgical treatment. How will they go about it? Well, how would most people take care of material possessions? For instance, if our auto was not running well most of us would take it to a place where we were sure there were well-trained mechanics. The human body is immeasurably more intricate than an auto. Who is trained to take care of it?

Men holding the degree of Doctor of Medicine have had four years of college. A few picked ones qualifying by rigorous examination have entered medical school and spent four years there. These medical schools are associated with the great centers of learning, and their teachers are recognized by the learned scientists of all branches—the biologists, physiologists, chemists, physicists, etc. After these schools the young doctors spend usually about two years as internes seeing in that time as many patients as most doctors see in a lifetime of private practice. Those going into the specialties then take some years as residents and for the rest of their lives they serve on the staffs of hospitals.

What are the qualifications by training of chiropractors, osteopaths, or members of any of the other so-called "systems" for treating human ills? They have nothing approximating this routine training of all medical men.

Osteopathy was founded over seventy years ago. In all that time it has brought forward nothing to convince the great body of scientific thought of the world that its theories are right. Has the University of Bologna, of Paris, Oxford, Cambridge, Harvard, Johns Hopkins, Columbia, or any other of the great educational institutions of the world established a school of osteopathy? Have insulin for diabetes, liver extract for pernicious anemia, sulfa drugs and penicillin for infections, the great surgical advances, x-ray or other laboratory methods of diagnosis been developed by osteopaths?

The Rhode Island Medical Society sponsored a plan for surgical care of the public. When reputable people "sponsor" anything there is at least an implied guarantee that they consider it good. The Rhode Island Medical Society does not consider that osteopathic training guarantees good surgery. The Society feels that it can guarantee good surgery through its members. It did not consider that it could handle the financing and management so asked the Blue Cross to do this for the physicians.

Now if anyone wants their auto tinkered with by a filling station attendant who undoubtedly is working about autos all the time, instead of taking it to an authorized Ford or Buick repair plant, he ought not in all conscience to expect those great firms to "sponsor" the proper working of their engines.

The daily paper continually refers to "the Blue Cross Plan." It is not that. It is the Rhode Island Medical Society's plan and the Society never sponsored a plan to have surgery done by untrained men.

BERTRAM H. BUXTON, M.D.

Dr. Bertram H. Buxton served as Business Manager of the RHODE ISLAND MEDICAL JOURNAL just after the first world war. It was rather a thankless job in those days. The Society was small and actually played second fiddle to the local Association with its nine meetings yearly.

This situation naturally reflected itself in the attitude of members towards their JOURNAL. We do not think it got the wholehearted support that it receives nowadays. But a few earnest men, recognizing its value, worked hard and gave their talents and caused it to prosper.

It was like Bert Buxton to be one of them. He was a brilliant student in college and medical school, but he played an active part in the extra-curricular activities which are also so worthwhile. After his hospital services he quickly developed a flourishing practice in obstetrics and gynecology, but he promptly left this and a growing family to go to the Mexican border with our troops and then in 1917 and 1918 had an outstanding record in France, being severely wounded in particularly hazardous rescue work.

continued on next page



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ARMY MEDICAL LIBRARY MICROFILM SERVICE

During the war, the Army Medical Library through its photoduplication services supplied millions of pages of microfilmed medical articles to the armed services and other research agencies. The principal of immediate aid direct to the user, wherever he might be, introduced a new technique to assist medical research.

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THE ROLE OF THE MEDICAL RECORD LIBRARIAN IN THE QUALITATIVE ANALYSIS OF HOSPITAL SERVICE*

Prepared by a SPECIAL COMMITTEE OF THE
RHODE ISLAND ASSOCIATION OF MEDICAL RECORD LIBRARIANS

THE systematic, periodic review and analysis of the clinical work of a hospital as recommended by the American College of Surgeons is aided by the keeping of the monthly and yearly statistics as outlined in the form, "Analysis of Hospital Service". The medical records librarian plays an important role in the recording of this data.

To obtain a degree of excellence in compiling reports from any source, simple forms are a basic must. Properly planned, a business form conveys information quickly and clearly, simplifies work, reduces mistakes and fixes responsibility. If the statistics in the various departments are recorded daily and monthly, and this monthly report sent to the medical records librarian or business office for compilation, there is not likely to be the danger of overlooking items. There is also the benefit of comparison from day to day, month to month, and year to year—growing into five, ten or more years. With such a system, the "Analysis of Hospital Service", may be easily kept. This paper will deal mainly with the data required on this special form.

Division of Services

On the "Analysis of Hospital Service," the number of patients discharged for the month or year is listed according to the following services, Medicine, Surgery, Obstetrics (delivered, not delivered, newborn), Gynecology, Eye, Ear, Nose and Throat, Urology, Orthopedics, Pediatrics, Dermatology, Communicable, Traumatic Surgery, Tumor and others. This listing informs the administrator and members of the staff of the amount of patients receiving treatment on each service. This division of patients according to the service is important for many reasons. At the present time, with the patients on the increase and the hospital space taxed beyond its normal limits, it gives an excellent basis in planning for additional space and in determining where it is needed. It also aids in investigating other dependent conditions such as adequate or inadequate nursing care, staff attendance, equipment, laundry facilities, housekeeping, medications, etc. In other words, the total number of cases treated provides the basic figures necessary for planning adequate hospitalization and its maintenance at all times.

*Read before the meeting of the R. I. Association of Medical Record Librarians on November 4, 1946, at Providence.

Results

One of the main values of the "Results" section of the analysis, at the present time, is to show the steady rise in the number of patients being discharged from the hospital each month and differentiate between those recovered, improved, unimproved, not treated, dead, and in for diagnosis only.

Deaths

At one of the hospitals in this state the following method is used in recording the deaths. Figures are readily available from the daily discharge record. Deaths are recorded as occurring under or over 48 hours, the latter being considered as institutional deaths. In the "Deaths" division, each death is recorded, giving the name of the attending physician, the case number and the diagnosis. This information is quickly obtained from the summary cards which are kept out of the file until the report has been completed.

Autopsies

The A.M.A. requires a minimum of 15 per cent of autopsies in the institutions approved for interns. The reason for this is that autopsies contribute toward scientific medical education. An increase in the percentage presents a picture of success by members of the hospital staff in obtaining accurate medical data made possible by the performing of autopsies. This knowledge is beneficial in the successful treatment of patients and verification of the diagnosis made of the cases. The securing of permission for autopsies is a very important procedure in a hospital. By the kindly and understanding attitude of the attending physician, the relatives of the deceased may be made aware of its importance to medical science.

A medical records librarian in this state reports: "During the past two years, a special effort has been made to increase the number of autopsies. The slogan, if such it can be called, is 'If the minimum autopsy rate is 15%, then each doctor should endeavor to get 15% of his service'. Our

continued on page 198



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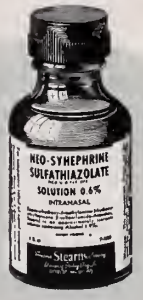
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ROLE OF MEDICAL RECORD LIBRARIAN

continued from page 196

autopsy rate was very much higher last year. The medical records librarian can do her part by just reminding the doctor that we have set a goal and it does help. Each month a report of deaths and autopsies for the month, and so far, during the year, is posted so that each doctor knows how he stands."

The medical records librarian for a specialized hospital of obstetrics cooperating with the Bureau of Census, Washington, D. C., may need to keep the following information by the month and year:

Total confinements
Total clinic confinements
Total private confinements
Total emergency confinements
Total number of primiparae confined
Total number of multiparae confined
Total number of multiple births
Total number of male infants
Total number of female infants
Total number of miscarriages or abortions
Total number of neonatal deaths
Total number of stillbirths
Total number of Caesarean Sections
Total number of Primary Sections
Total number of forceps deliveries

If the Bureau of Census, Washington, D. C., should ask for information on the above statistics in relation to maternal death, the information is available. All complications of pregnancies are compiled each day.

Statistics on Maternal Deaths

Total number of obstetrical deaths
Total number of live births in the state
Maternal death rate in the state
Total number of obstetrical deaths at the hospital
Deaths in which hypertensive toxemia was present
Number developing convulsions
Deaths in which abortion played a primary or secondary role
Deaths in which hemorrhage played the major or minor role
Deaths in which infection played a major or minor role
Deaths in which Caesarean sections were performed

Classification of Prenatal Care at a local hospital is as follows:

Class I—Good prenatal care. It consisted in the patient reporting to the physician or clinic in the second month. A general medical and obstetrical examination was made and later regular visits at which blood pressure reading and urinalysis was done.

Class II—Fair prenatal care. It began not later than seventh month with some diagnostic and follow-up care as above.

Class III—Poor prenatal care. This at times began in the early months but was not constant or else it may have consisted in only one visit.

Consultations

Fifteen to twenty per cent of patients treated is a good indication that patients are being studied and are receiving the benefit of expert medical opinion and advice. Some services such as medicine, surgery, pediatrics and orthopedics may lead in the percentage obtained.

Attendance at Staff Conferences

The recording of the attendance of the staff at monthly conferences serves as an appraisal of the interest being shown in the professional work of the hospital. If the attendance is not sufficient, the administrator and medical staff will realize more interest is necessary and will take proper steps to stimulate the members of the staff. Seventy-five per cent attendance per member at staff meetings for the year is the recommendation of the College of Surgeons.

Infections

Purpose of Recording Infections:

So that they may be carefully reviewed, a record should be kept of all infections. Those not present on admission but occurring in the hospital are known as hospital infections and require special attention for the study of their prevention. This tabulation should include the more obscure ones as well as the obvious infections, such as those following surgery. Communicable diseases, whether or not they are to be considered hospital infections, must be reported to the local health department.

Classification of Infections:

To classify an infection, the cause must be ascertained in order to determine under which service it originated, as that will be the service debited. For this purpose, the medical records librarian, as she is not qualified to judge, should consult an appointed medical officer before entering the infection under the proper service in the monthly analysis, which will give the total number of infections assigned to each service, list the percentages, and state individual cases to make the information readily available for staff conferences.

Review of Infections Recorded:

It is only through discussion and study by the staff of the cases in question that prevention of possible infections will be brought about. In some instances, it may be debatable whether or not the infection was preventable, and a check on technique may be made. In other clear-cut cases, the cause should be sought, and from it may come a clue for further prevention. For example, at a children's psychiatric hospital, where all patients are ambulatory, it has been found very helpful in preventing upper respiratory infections to have all visitors and

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WOMAN'S AUXILIARY ORGANIZED

An organization meeting to form a Woman's Auxiliary to the Rhode Island Medical Society was held at the Medical Library on Wednesday, February 5, 1947. The meeting was called to order at 3 p.m. by Dr. Herman C. Pitts, President of the Society, at whose call the meeting was held.

Dr. Pitts explained that the House of Delegates of the State Medical Society had authorized him to have a committee of the county society presidents discuss the feasibility of an auxiliary. This committee had approved of the recommendations that an auxiliary be started if the wives of the physicians in Rhode Island were interested. Therefore, he stated that the meeting had been called to discuss the matter. He presented Mrs. James R. Miller, of Hartford, Connecticut, Past-President of the Woman's Auxiliary to the Connecticut State Medical Society.

Mrs. Miller explained the organization work of the Woman's Auxiliary and she spoke on the duties and programs of Auxiliaries in general. She reported that there are now forty-three states with Woman's Auxiliaries to the state medical society. She stated that the primary purposes of the Auxiliary are to extend the aims of the profession to all organizations that work for the advancement of health, to promote mutual understanding among physicians' families, and to participate in activities at the request of the State Medical Society.

After Mrs. Miller's address and after questions addressed to her from the floor had been answered, Dr. Pitts asked if it were the wish of the women present that they form an auxiliary to the State Medical Society. On a show of hands the vote was unanimous in favor of forming an auxiliary. Therefore, Dr. Pitts announced that the next procedure would be for the group present to elect a temporary Chairman in order to proceed with the organization. He called for nominations.

The name of Mrs. Herbert E. Harris was placed in nomination as temporary Chairman of the Auxiliary. The nomination was seconded. Nominations were closed and Mrs. Harris was elected temporary Chairman of the meeting.

Mrs. Harris called for nominations from the various districts of the State to form a committee which would serve as a board of directors with the officers until such time as the constitution and by-laws of the Auxiliary are drafted and accepted by the membership. She also asked that such a committee serve as a nominating group to recess and bring in at the meeting a list of officers to serve until the constitution is drafted. Nominations were made as follows: from Woonsocket, Mrs. H. Lorenzo Emidy; from Pawtucket, Mrs. Henry J. Hanley; from Bristol County, Mrs. Arcadie Giura; from Newport County, Mrs. Alfred Tartaglino; from Washington County, Mrs. Thomas Nestor; from Kent County, Mrs. Stanley D. Davies.

Mrs. Harris stated that in view of the fact that the largest representation would be from the Providence Medical District it would be advisable that there be several nominations from whom one should be selected by the members present. As a result, the following were placed in nomination as the candidates from the Providence District and a written ballot was taken:

Mrs. Philip Batchelder, Mrs. Bertram H. Buxton, Mrs. William P. Davis, Mrs. Louis I. Kramer, Mrs. John Langdon, Mrs. Daniel V. Troppoli, Mrs. Guy W. Wells, Mrs. Thomas Dolan.

On a written ballot Mrs. Thomas Dolan was elected from the Providence District.

Mrs. Harris requested that the committee recess and bring back a slate of officers. During the recess Mrs. Miller amplified her remarks to the group relative to the work that the Auxiliary could do, and Dr. Pitts also spoke pointing out the fact that the Auxiliary could assist in combating the propaganda for State, or Socialized, Medicine.

After the recess the nominating committee presented the following slate of officers to serve until such time as the constitution of the Auxiliary is accepted:

President:	Mrs. Herbert E. Harris
Vice President:	Mrs. Guy W. Wells
Secretary:	Mrs. Charles L. Farrell
Treasurer:	Mrs. Jesse P. Eddy, 3d

The above slate was voted upon individually and each candidate was elected to serve.

Mrs. Harris suggested that the Auxiliary might work on its by-laws and possibly have a meeting in conjunction with the State Medical Society meeting in May. She stated that she would call upon the members of the committee and the other officers to work on details in the immediate future.

The meeting adjourned at 4:20 p.m.

Respectfully submitted,

Mrs. Charles L. Farrell, *Secretary*

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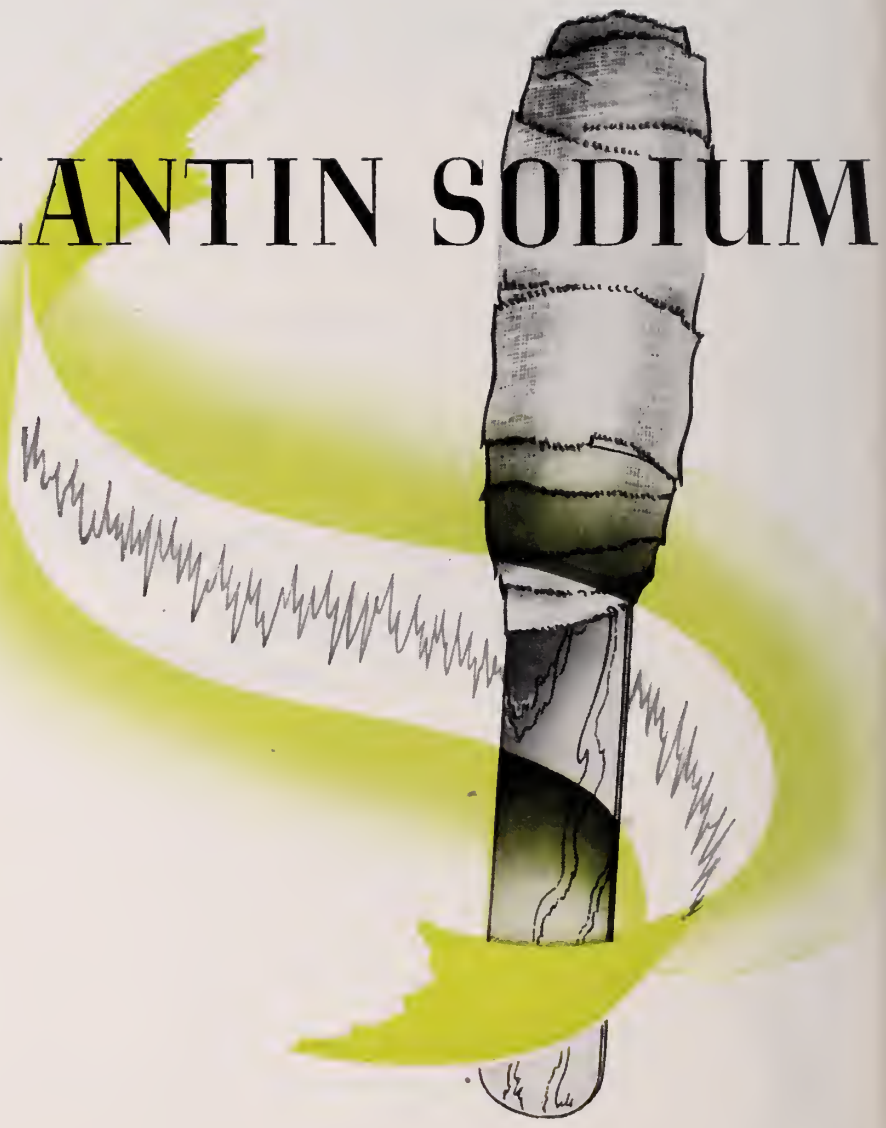
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DISTRICT SOCIETY MEETINGS

KENT COUNTY MEDICAL SOCIETY

At the annual meeting of the Kent County Medical Society the following officers were chosen to serve for 1947:

President:	Peter C. Erinakes, M.D.
Vice President:	Jeannette E. Vidal, M.D.
Secretary:	Joseph K. Harrop, M.D.
Treasurer:	John A. Mack, M.D.
Censor:	George L. Young, M.D., for three years
Ethics:	John A. Mack, M.D., for three years
Trustees:	Fernand J. Hemond, M.D., for three years
	Arthur E. Hardy, M.D., to fill unexpired term of Kathryn Hardy, M.D., for one year
	Jean Maynard, M.D., for three years
Nominating Committee:	Fenwick Taggart, M.D.
	Royal Hudson, M.D.
	George Farrell, M.D.

The Society also ruled to change the date of its meetings from the first Thursday of every month to the first Tuesday of every month at 9:00 p.m. The meeting places are to be left to the President of the Society.

Respectfully submitted,

JOSEPH K. HARROP, M.D., *Secretary*

The February meeting of the Kent County Medical Society was called to order at 9:10 p.m., February 4, 1947, at the Club Frontenac, West Warwick, Rhode Island. This was the first night meeting in several years, and despite very inclement weather, seventeen members were in attendance.

The minutes of January's meeting were voted, accepted, and incorporated into the record.

Mr. Puritan, a representative of the Loyalty Group Insurance Company, addressed the session briefly on the merits of Group Disability Insurance and urged Society acceptance of such a plan as offered by his company. After short discussion, it was voted to table further consideration of this plan to a later date.

The President then opened discussion as to the site of future Medical Society meetings. It was decided to hold the March meeting at Dr. Erinakes' office, and to continue the present investigating committee's efforts in locating permanent meeting places both in Warwick and in West Warwick, until such time that the proposed Hospital becomes a reality and solves this problem.

Some of the aspects of socialized medicine were briefly touched upon by the Society President, and it was agreed to invite a council member of the Rhode Island Medical Society to address this body on the subject at a later date.

Dr. Stanley Davies presented a thorough discussion of the RH factor and implemented his talk with case histories. A rising vote of appreciation was accorded his paper.

The meeting was adjourned at 10:45 p.m.

Respectfully submitted,

FRANCIS LAMB, M.D., *Secretary, Pro tem*

WASHINGTON COUNTY MEDICAL SOCIETY

The annual meeting of the Washington County Medical Society was held at the Westerly Hospital, January 8, 1947, at 11 a.m.

The minutes of the October meeting were read and approved.

The President gave a report of the meeting of the county society presidents with the President of the State Society at Newport.

It has been suggested that a Woman's Auxiliary composed of wives of Rhode Island physicians be formed.

The House of Delegates at its last meeting authorized that the State dues be raised to $40 a year.

A letter was read from Dr. Jacob P. Warren, now residing in Westerly, asking that his membership be transferred from Providence to Washington County. The By-Laws were suspended and this was voted upon and passed.

Dr. Elmer T. Gale of Wakefield was accepted into membership.

A letter was read from Dr. Robert McC. Halbach, now Chief of Medical Service in the Veterans Hospital, Livermore, California, who wishes to retain his membership in this Society. The Secretary was instructed to assure him that he is still a member.

The President appointed Drs. Cerrito, Tully and Farago a nominating committee to bring in a slate of officers for the year 1947.

While they were deliberating, the Treasurer's report was read, accepted and ordered placed on file.

continued on page 206



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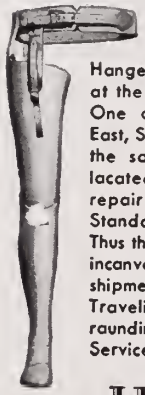
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WASHINGTON COUNTY SOCIETY

continued from page 204

The Committee then presented the following slate of officers which was accepted by vote:

President:	Louis Morrone, M.D.
1st Vice President:	Samuel Farago, M.D.
2d Vice President:	Samuel Nathans, M.D.
Secretary-Treasurer:	Julianna R. Tatum, M.D.
Censor for 3 years:	Sylvester Capalbo, M.D.
Auditor:	Thomas Nestor, M.D.
Delegate for 2 years:	Hartford P. Gongaware, M.D.
Councillor:	John P. Jones, M.D.
Member of Public Policies Committee:	Louis C. Cerrito, M.D.

The speaker of the day was then introduced. Dr. Arthur H. Ruggles, of Butler Hospital, Providence, spoke on the Rhode Island Surgical Plan, giving a history of the plan since it was first proposed by the Rhode Island Medical Society. It is ready to put into effect now, but the Blue Cross wishes to include osteopaths, and until this question is settled it cannot be offered to the public.

Mr. John E. Farrell, Executive Secretary of the Rhode Island Medical Society, also explained some features of the Plan, and there were many questions from the floor and a good deal of discussion.

The meeting adjourned at 1 p.m. Dinner was served at the Elm Tree Inn to members and guests.

Respectfully submitted,

JULIANNA R. TATUM, M.D., *Secretary*

WOONSOCKET MEDICAL SOCIETY

A meeting of the Woonsocket Medical Society was held at the Oakes on Elm Street in Woonsocket on Tuesday, January 21, 1947. The meeting was called to order at 9:45 p.m. by Dr. Joseph Reilly, President.

The meeting was devoted entirely to discussion of communications and business matters. There was no speaker of the evening. A buffet supper was served at the conclusion of the session. Attendance 21.

Respectfully submitted,

ALFRED E. KING, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was called to order by the President, Dr. William Kalcounos, at 9:00 p. m. in the Nurses' Auditorium of the Memorial Hospital February 20, 1947.

The minutes of the previous meeting were read and accepted.

The applications for membership of Dr. Rocco Bruno, Dr. James G. Chapman and Dr. Bencel L. Schiff were unanimously approved after they were submitted to ballot.

continued on page 208

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PAWTUCKET MEDICAL ASSOCIATION

continued from page 206

A group insurance plan offered by the Loyalty Group Insurance Co. was reported as approved by the Society officers.

A communication from the executive secretary of the Rhode Island Medical Society was read.

Dr. J. Lincoln Turner introduced the guest speaker, Dr. Paul Appleton of Providence, who spoke on "Abnormalities of the Newborn," and presented a film of his own illustrating a variety of infant abnormalities. A brief discussion period followed and the meeting adjourned at 10:00 p. m.

Respectfully submitted,

KIERAN W. HENNESSEY, M.D., *Secretary*

NEWPORT COUNTY MEDICAL SOCIETY

At the annual meeting of the Newport County Medical Society on January 28, 1947, the following officers were elected:

President	Alfred M. Tartaglino, M.D.
1st Vice President	William A. Stoops, M.D.
2d Vice President	Philomen P. Ciarla, M.D.
Secretary	Henry W. Brownell, M.D.
Treasurer	Norbert U. Zielinski, M.D.
Delegates	Louis E. Burns, M.D.
	James C. Callahan, M.D.
Councilor	Samuel Adelson, M.D.
Censors	Norman M. MacLeod, M.D.
	John A. Young, M.D.

Respectfully submitted,

HENRY W. BROWNELL, M.D., *Secretary*

NEW FELLOWS OF THE RHODE ISLAND MEDICAL SOCIETY

Pawtucket Medical Association

Louis E. Hanna, M.D., 164 Central Ave., Pawtucket

Providence Medical Association

Earle H. Brennen, M.D., 58 John St., Providence
Vincent A. Cianci, M.D., 54 Pocasset Ave., Providence
James H. Crowley, M.D., 1656 Broad St., Providence
Thomas H. Murphy, M.D., 1008 Smith St., Providence
Bradford M. S. Portnoy, M.D., 672 Broad St., Providence
Agostino Sammartino, M.D., 257 Academy Ave., Providence
William J. Schwab, M.D., 616 Hope St., Providence
Thomas P. Sheridan, M.D., 118 Prospect St., Pawtucket
Charles Zurawski, M.D., 30 Olneyville Sq., Providence

Washington County Medical Society

Elmer Thomas Gale, M.D., 25 Mechanic St., Wakefield



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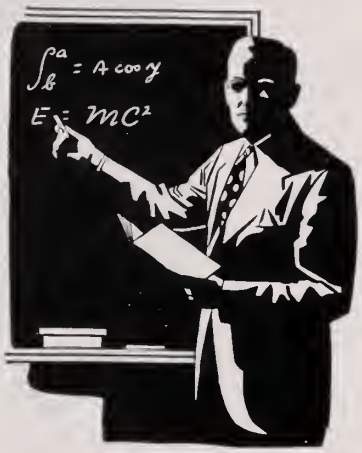
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His diet is balanced, *yet he is a borderline vitamin deficiency case.* Like many others whose occupations are sedentary and who take little exercise otherwise, his caloric requirements and appetite are so small that he simply does not eat *enough* food to supply adequate quantities of the protective factors. As a result his case record has taken its place in his physician's file along with those of all of the other varieties of dietary delinquents: the ignorant and indifferent, patients "too busy" to eat properly, those on self-imposed and badly balanced reducing diets, excessive smokers, alcoholics, and food faddists, to name but a few. First thought in such cases is dietary reform, of course. But this is often more easily advised than accomplished. Because of this, an ever-growing number of physicians prescribe a vitamin supplement in every case of deficiency. If you're one of these physicians—or if you prescribe vitamins only rarely—consider the advantages of specifying an *Abbott* vitamin product: Quality—Certainty of potency—A line which includes a product for almost every vitamin need—And easy availability through pharmacies everywhere. ABBOTT LABORATORIES, North Chicago, Ill.

SPECIFY:

Abbott Vitamin Products



PETER ERINAKES, M.D.
of Kent County, R. I.
President, 1947
Kent County Medical Society



LOUIS A. MORRONE, M.D.
of Westerly, R. I.
President, 1947
Washington County Medical Society



ALFRED M. TARTAGLINO, M.D.
of Newport, R. I.
President, 1947
Newport County Medical Society

Trauma and Nitrogen Equilibrium

Recent recognition of the direct relationship between trauma and protein loss has greatly improved the prognosis in postsurgical and post-trauma patients.

Striking and hitherto unsuspected protein loss has been observed in patients with fractures. Excessive urinary nitrogen excretion reaches its maximal point about a week after the injury is sustained, and thereafter slowly diminishes in extent, so that nitrogen balance is restored in approximately four weeks.[1]

In patients sustaining severe burns, the daily protein loss may be equivalent to 400 cc. of plasma.[2]

In a study embracing 23 burned patients, nitrogen balance determinations revealed excessive urinary nitrogen excretion. Nearly all patients were in negative nitrogen balance which was most marked during the first ten days.[3]

It thus appears that protein destruction and loss are prominent and potentially detrimental sequelae of trauma, and that every effort must be made to restore nitrogen equilibrium as quickly as possible to prevent the many deleterious consequences of protein depletion. The recommendation has been voiced that "whenever possible, protein losses or deficiencies should be corrected by oral feeding."[4]

Among the protein foods of man, meat ranks high not only because of the generous supply of protein it provides, but also because its protein supplies all the essential amino acids, making it applicable for every protein need—growth, tissue maintenance, and tissue repair.

---

1 Howard, J. E.: Bull. Johns Hopkins Hosp., *74*:313 (May) 1944.

2 Co Tui, C.; Wright, A. M.; Mulholland, J. H.; Barcham, T., and Breed, E. S.. Ann. Surg. *119*:815-823 (June) 1944.

3 Hirshfeld, J. W.; Abbott, W. E.; Pilling, M. A.; Heller, C. G.; Meyer, F.; Williams, H. H.; Richards, A. J., and Obi, R.: Arch. Surg. *50*:194 (Apr.) 1945.

4 Lund, Chas. C., and Levenson, S. M.: J. A. M. A. *128*:95 (May 12) 1945.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED AMERICAN MEDICAL ASSN Council on Foods and Nutrition

AMERICAN MEAT INSTITUTE

MAIN OFFICE, CHICAGO ... MEMBERS THROUGHOUT THE UNITED STATES

OUR LATEST ENDEAVOR — MICROFILMING

ELIZABETH BINGHAM, R.R.L.

The Author. *Elizabeth Bingham, R.R.L., Medical Records Librarian, St. Joseph's Hospital, Providence, R. I.*

IN view of the fact that as the years have rolled along the administrators and medical profession have brought hospitals up to such high standards by giving only the best medical and nursing care and seeing to it that the patients enjoy every possible comfort, people have become more and more hospital-minded, losing the fear that they once had, so now they do not hesitate to enter a hospital when their physician advises them to do so.

Statistics in this Hospital show that the number of admissions have increased so that now there are three and one-half times more cases admitted than there were in 1917. It is, as most of you know, a ruling that we keep records indefinitely in order that they may benefit the patient in case of illness in the future and also for research purposes. You can well understand therefore, that we must have some method for storing these records and that as the number of admissions have multiplied, so, too, have the number of charts and that now we at St. Joseph's Hospital have well over 125,000 records which represents over 1,000,000 pieces of paper and we are faced with the problem of finding space large enough to store all this data. Not only were we concerned about the volume of space required to house these valuable records, but we realized the chaos that would be created if these records were destroyed through fire, deterioration or other causes. It is general knowledge that all hospitals are overcrowded and that every available room is being utilized and we realized that some drastic action would have to be taken to alleviate this situation. We visited various microfilm installations, contacted several organizations engaged in microfilming hospital records and came to the conclusion that if we were to secure adequate breathing space, we would have to file our records on microfilm.

Microfilming is the photographing of the original record condensing it to such a degree that it is possible to have from 2750 to 2800 images on one roll of film. It is permanent in that it is non-inflammable and is filed in humidified cabinets; it will last longer than the best rag content paper. It is compact in that whereas at the present time it takes 284 corrugated files to retain records from 1916 to 1940—approximately 710 square feet of floor space, after these records are all filed-on-film, we will have 275 rolls of film which can be housed in three desk drawers. Our saving space will be over 99%.

We decided that we would microfilm all cases through 1940 at the present time, keeping records from 1940 to date in their paper form. Next year we will microfilm the records for the year 1941 and each succeeding year we will microfilm one more year's records. This will maintain our present filing space requirements at a constant figure. We know how much space we require and know that it will never increase.

We carefully studied the legal aspects of the admissibility of facsimiles made from properly certified microfilm and find that these facsimiles are fully acceptable. There is no question of Intent to Defraud on a certain record when all records of a given group or period have been filmed. Specific legality of the photographic process is unquestionable.

With this system it is impossible to have any misfiled charts. It is accessible in that when a record is requested it will take only one and one-half minutes to locate it by use of special micromatic controls. The record can be enlarged by the Film-a-record's projector so that it is very easy to peruse, and is much cleaner to handle. It is a time saving device in that the record can be reproduced and as many copies as necessary made, thus eliminating hours of typing of abstracts to be sent to Insurance Companies, Lawyers, Doctors and other Hospitals and will release a clerk for other duties. It is accurate because it is an exact copy of the original record.

Following are a few suggestions which would be well to consider when writing records which are to be microfilmed:

1. Errors should be put in parentheses rather than crossed out, the correction being made following the parentheses.
2. Charting should be recorded on only one side of the paper, additional sheets being used if necessary.
3. Writing should be as legible as possible, and black or dark blue ink used.



EFFECTIVES . . . but not cure-alls

Modern therapeutics support the premise that no single medication will successfully combat all ear conditions. For that reason . . . DOHO, specialists in the development of effective ear medications . . . offer

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When pain, fever, edema, leucocytosis, sense of fullness and impaired hearing are present—AURALGAN by its potent decongestant, dehydrating and analgesic action provides effective relief of pain and inflammation.

O-TOS-MO-SAN

IN CHRONIC SUPPURATIVE OTITIS MEDIA

O-TOS-MO-SAN provides a new Sulfa combination of Sulfathiazole and Urea in Auralgan Glycerol (DOHO) base, completely water-free and having the highest specific gravity obtainable — scientifically developed.

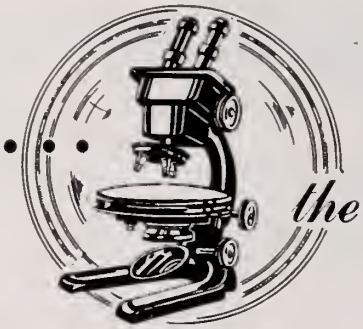
O-TOS-MO-SAN exerts a powerful solvent action on protein matter . . . liquefies and dissolves exuberant granulation tissue . . . cleanses and deodorizes the site of infection . . . and tends to exhilarate normal tissue healing in the effective control of chronic suppurative Otitis Media. Excellent results have also been obtained in furunculosis of the external ear canal.

NOTE:
Where there is an intact ear drum, neither Sulfonamides nor Urea are effective . . . and under these conditions AURALGAN is indicated.

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The indiscriminate use of the Sulfonamides should be avoided—so that infectious organisms do not become "sulfa-fast" or patients "sensitive" to Sulfa.

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THROUGH . . .  *the Microscope*

HOSPITAL INSURANCE:

The problems of the hospitals and the Blue Cross in Connecticut flared anew recently when the William W. Backus Hospital in Norwich withdrew from the Blue Cross program because of the disagreement over the contracts. In a statement to the press the Hospital pointed out that the problem had developed between the Blue Cross and several Connecticut hospitals around the fact, which is not generally known by Blue Cross members, that the Blue Cross issues two separate contracts — one to the subscriber and one to the member hospitals. In its statement the hospital pointed out that whereas the subscriber's contract calls for provision of many services, the one with the hospitals calls for a straight $6.00 allowance towards the room rate and $2.60 per day as a guarantee for the additional services regardless of the amount of the services used. Moreover, in the contract with the hospital, the Blue Cross will not permit the hospital to collect from the patient the difference between $2.60 per day and the total charges for special services rendered, and neither will the Blue Cross pay the hospital the difference. Faced with the difficulty of making up its loss out of its trust fund earnings the hospital found that it could operate better outside the Blue Cross service and, therefore, it has resigned.

* * * * *

The Medical Society of the County of Queens (New York) recently received a report from its committee concerning withdrawal of recognition of the Associated Hospital Service of New York unless it ceases to include provision of medical services with the hospital contract. The objection is based on the fact that roentgenology and pathology are included as hospital services under this plan.

* * * * *

A recent press story in the *Providence Journal* reported that the Hospital Association of Rhode Island has urged upon the General Assembly the passage of a bill to increase from $4.50 to $8.00 the maximum daily rate allowed for hospitalization in workmen's compensation cases. Support for the measure was urged on the grounds that it is estimated that the voluntary hospitals of this State are spending on the average well in excess of $12.00 a day in providing care to workmen's compensation cases. The question in the minds of some members of the Assembly is that if the private insurance carrier is to pay an increase for workmen's compensation policy holders then should the non-profit Hospital Service Corporation not meet the same standard of payment to every hospital in the State.

* * * * *

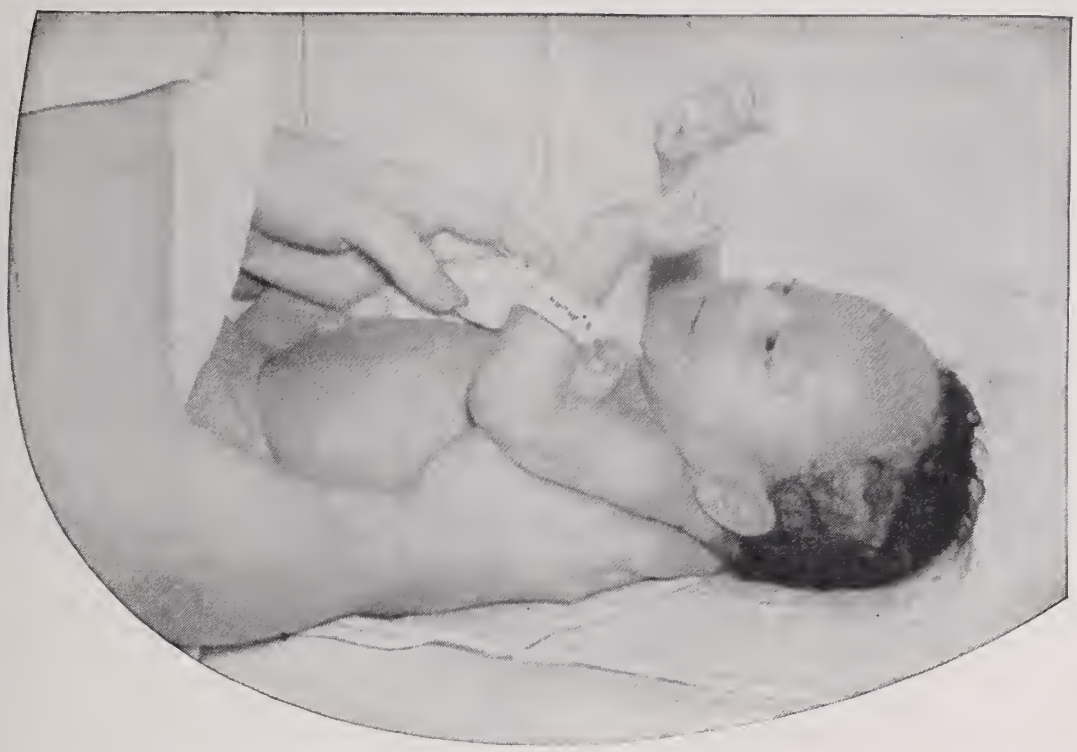
THE PUBLIC'S HEALTH

Provisional reports just received from the Federal Security Agency indicate that a total of 3,260,000 births were registered in the United States in 1946. This figure surpasses the previous high record of 1943 by 11 per cent. In spite of the increase in births in Rhode Island as shown in the recent Rhode Island Hospital survey the population is predicted to swing downward so that by 1960 there will be an estimated 689,000 people in the state as against a possible 697,000 in 1950. Rhode Island, incidentally, shared with Nebraska the lowest infant mortality rate in the country during 1945 with only 28.2 deaths per thousand live births, according to U. S. Public Health Birth Service.

* * * * *

Anti-vivisection bills have recently been introduced in Congress and in the state legislatures of Massachusetts, California and Wisconsin. Undoubtedly similar bills will be introduced in a number of other state legislatures. As a result of this action suggestions have been advanced that a statute providing for the use of pound dogs for medical experiments be introduced to meet anti-vivisection legislation.

* * * * * *continued on page 216*



Premature, but promising

To the premature struggling for existence, intestinal distention, colic or diarrhea may be insurmountable obstacles. Good care and good nutrition, however, offer promising prospects for life and health.

In the feeding of premature infants, 'Dexin' has proved an excellent "first carbohydrate." Because of its high dextrin content, it (1) resists fermentation by the usual intestinal organisms, (2) tends to hold gas formation, distention and diarrhea to a minimum, and (3) promotes the formation of soft, flocculent, easily digested curds.

Readily soluble in hot or cold milk, or other bland fluids, 'Dexin' brand High Dextrin Carbohydrate is well taken and retained. 'Dexin' *does* make a difference.

'Dexin' BRAND HIGH DEXTRIN CARBOHYDRATE

Composition—Dextrins 75% • Maltose 24% • Mineral Ash 0.25% • Moisture 0.75% • Available carbohydrate 99% • 115 calories per ounce • 6 level packed tablespoonfuls equal 1 ounce • Containers of twelve ounces and three pounds • Accepted by the Council on Foods and Nutrition, American Medical Association.
'Dexin' Reg. Trademark

Literature on request

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THROUGH THE MICROSCOPE

continued from page 214

The action of the Providence Medical Association a year ago in the initiation of a campaign of smoke abatement has finally culminated in the enactment of a new city ordinance regulating the pollution of the air in Providence. All that remains now is the setting up of the office of the Chief Air Pollution Regulation Engineer and the proper supervision and policing of all fuel burning equipment in the city. Meanwhile, across the country the Los Angeles County Medical Association has offered its services in the campaign to reduce the smog nuisance in that area on the grounds that smog is detrimental to the health of the people.

* * * * *

Fewer deaths occurred in the United States during 1945 than either the two preceding war years. Deaths from the major infectious diseases declined to a new low, and tuberculosis continued its decline. Heart disease, cancer and intracranial lesions strengthened their positions at the head of the list of the leading causes of death. Motor vehicle accidents lead all other types of accidental causes of deaths with a total of 28,000 out of an overall total of 95,918 from all accidental causes.

* * * * *

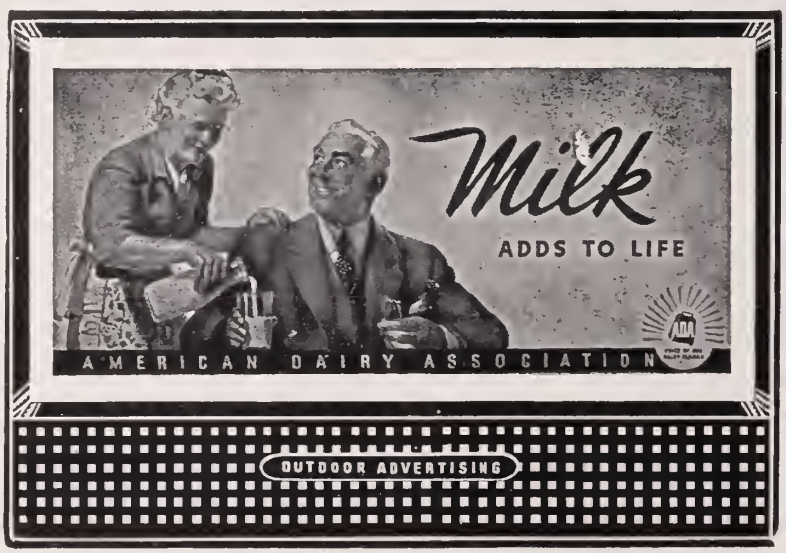
PUBLIC RELATIONS

At the December meeting of the House of Delegates of the American Medical Association the report on the survey of the public relations of the Association made at the request of the Board of Trustees early in 1946 by Raymond Rich and Associates of New York City was discussed by the Delegates. Inasmuch as this report is copyrighted by the AMA it cannot be reproduced in the RHODE ISLAND MEDICAL JOURNAL until permission is given by the AMA. At this writing no word has been received from the officers of the American Medical Association authorizing the reprinting of any of the report despite of the fact that at the meeting of the House the statement was made that the various state medical journals would be issued a report that they might print.

The major controversy regarding the Rich report pertained to the National Physicians Committee (NPC). This latter organization was criticized by Mr. Rich as regards its value to the AMA. He stated that his investigation had shown that some of the activities of the NPC had resulted in criticism of the medical profession from many sources, and therefore he felt that approval of the group should not be renewed. Likewise he felt that any interlocking of the directors of the two

continued on page 218

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speaks to those persons of middle life and beyond.

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SPOT TESTS

SIMPLIFY URINALYSIS

NO TEST TUBES • NO MEASURING • NO BOILING

Diabetics welcome "Spot Tests" (ready to use dry reagents), because of the ease and simplicity in using. No test tubes, no boiling, no measuring; just a little powder, a little urine—color reaction occurs at once if sugar or acetone is present.

Galatest
FOR DETECTION OF SUGAR IN THE URINE

Acetone Test (DENCO)
FOR DETECTION OF ACETONE IN THE URINE

THE SAME SIMPLE TECHNIQUE FOR BOTH

1. A LITTLE POWDER



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COLOR REACTION IMMEDIATELY



A carrying case containing one vial of Acetone Test (Denco) and one vial of Galatest is now available. This is very convenient for the medical bag or for the diabetic patient. The case also contains a medicine dropper and a Galatest color chart. This handy kit or refills of Acetone Test (Denco) and Galatest are obtainable at all prescription pharmacies and surgical supply houses.

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Specializing in Prescriptions and Surgical Fittings

EIGHT REGISTERED PHARMACISTS

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"If It's from Brown's, It's All Right"

THROUGH THE MICROSCOPE

continued from page 216

organizations should be discontinued. The House of Delegates finally recommended further study of some of these matters and the Committee of the House was instructed to continue its investigation and to report at the Centennial Meeting at Atlantic City in June, 1947.

* * * * *

In Pennsylvania where the same Raymond Rich conducted a study of the Public Relations Program of the State Medical Society, a Committee of the Society has accepted some of the recommendations advanced, including the utilization of a budget of $15,000 allocated to the Committee to carry on a revamped program of public relations throughout the State. Under this new plan the present Executive Secretary of the Society, with the assistance of adequate office help, will endeavor to develop a corps of more than a hundred member-speakers scattered throughout the State ready and willing to accept calls from county medical societies and lay organizations for speakers on socio-economic subjects related to the practice of medicine. Later, the expanded program will include the preparation and distribution of pamphlets, motion picture presentations, and radio forum discussions.

* * * * *

In Alameda County (California), the Medical Association has purchased advertising space in the daily newspapers to carry on a public attack against Governor Earl Warren's proposal to back a health insurance program in the 1947 California Legislature. The advertisements immediately set off a public discussion between the Association and the Governor on the merits of his health program which he later introduced in the General Assembly of that State.

* * * * *

In direct antithesis of these efforts to bring to the general public the viewpoint of organized medicine we note what appears to us the most unusual attitude taken by the Medical Society of Orleans (Louisiana) Parish. In that Society the Judiciary Committee submitted a report in December which included among other restrictions that in the future the Society discontinue forwarding the Society's bulletin to the local press and all other non-medical organizations under any conditions. Going even further than this, the report would have the Society ban press releases from medical conventions picked up by the national wire services and reprinted in the local newspapers concerning members of the Society reading papers at such conventions, and would also prohibit a mention in the

continued on page 220

What's in a NAME?

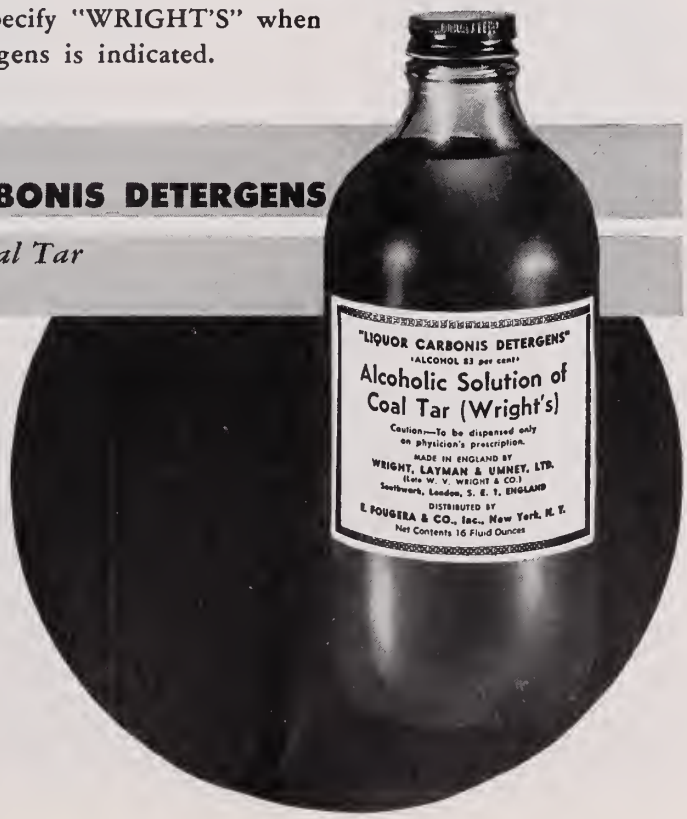
In the name "WRIGHT'S", associated with LIQUOR CARBONIS DETERGENS, there is the prestige of product originality plus the dependability which can be found only when manufacturers have had long experience with special formulas.

WRIGHT'S LIQUOR CARBONIS DETERGENS was originated in 1862. Since then, specialized skills have been devoted to its production and to the maintenance of a high standard of quality, uniformity, and dependability.

To insure the patient's receiving the full benefit of the medication specify "WRIGHT'S" when Liquor Carbonis Detergens is indicated.

WRIGHT'S LIQUOR CARBONIS DETERGENS

Solution of Coal Tar



A topical dermatologic and antipruritic agent for use in lotions or ointments.
SUPPLIED in bottles of 3 fl. oz., 1/2 pt., and 1 pt.

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GENERAL MOTORS
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COAL OIL

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REGIONAL FRACTURE COMMITTEE

The Regional Fracture Committee of the American College of Surgeons plans to hold clinics throughout the year at various hospitals and clinics in the State of Rhode Island. The Committee is especially anxious to have general practitioners, physicians interested in industrial work and orthopedic and fracture men attend these meetings.

First, meetings will consist of ward walks in various hospitals in the City of Providence. Later, clinics will be held in hospitals outside of Providence. The next meeting of this group will be held on April 24, 1947, at St. Joseph's Hospital. The meeting will start in the Orthopedic Clinic at 10 a.m.

THROUGH THE MICROSCOPE

continued from page 218

newspapers of members of the Society being elected to an office in the Society, the Louisiana State Medical Society, specialty organizations, hospital staffs, etc. With all due credit to the thinking that has prompted such a conclusion we must observe that in the light of what is the trend throughout the country regarding medical society relations this proposed action is most definitely a step backwards.

* * * * *

LEGISLATION

When Senator William J. Thompson of Cranston made his statement as quoted in the *Providence Journal* that he "did not like" the attitude of the Rhode Island Medical Society because it opposed the inclusion of osteopaths in a proposed pre-paid non-profit surgical care program that would be administered by the Blue Cross, the newspaper which had been very careful in all previous releases to point out osteopathic views failed to inform its readers that Senator Thompson was not necessarily speaking as the GOP floor leader but rather as an individual member of the Assembly who is *a trustee* of the Rhode Island Osteopathic Hospital. Senator Thompson has long been a supporter of osteopathic legislation and therefore it was not surprising that he should be the spokesman in the Assembly.

* * * * *

Copies of the revised Taft-Smith-Ball-Donnell Bill to enact the national health act, S.545, have been received and had been distributed to the Secretaries of the county medical Societies. This measure was introduced on February 10 and was referred to the Senate committee on labor and public welfare of which Senator Taft is chairman. Two significant changes have been made in the measure to provide that the administrator of the national health agency will be a Doctor of Medicine licensed to practice in one or more of the states, and who is outstanding in the field of medicine. In the initial version of the bill it was provided that the administrator could be a Doctor of Medicine with at least eight years of experience in the commissioned corps of the United States Public Health Services. Under the provisions of the first bill, also, the Surgeon-General of the Public Health Service was designated as the Federal Administrative Officer to supervise the operation of state programs to provide medical and hospital care for families and individuals of low income. The new bill creates in the National Health Agency an office of medical and hospital care services to supervise such programs, headed by a Doctor of Medi-

continued on page 222

In a continuing program to maintain the highest possible standards of sanitation and purity throughout every step of its operation, H. P. Hood & Sons keeps a careful check upon the health of its employees. A practicing physician examines *every* employee in *every* Hood Milk plant *every* week. Furthermore, before being accepted for employment, each applicant must pass a physical examination conducted by a practicing physician. These safeguards pay health dividends.

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When considering the purchase of gem jewelry, we should be pleased to have you consult one of our staff who has earned his degree in the scientific study of gem stones.

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MEDICAL-LEGAL SOCIETY ELECTS

The RHODE ISLAND MEDICAL-LEGAL SOCIETY which has been inactive during the war years held a meeting at the Medical Library on February 20 for the election of officers to plan for future programs for the organization. Re-elected as president was Dr. William H. Foley, physician-lawyer, of Providence. The new vice president is James L. Loft, Esq., while Thomas L. Haire succeeds the late William H. S. Callahan as secretary-treasurer.

THROUGH THE MICROSCOPE

concluded from page 220

cine licensed to practice medicine who has had at least five years of active medical practice and who is outstanding in the field of medicine.

* * * * *

Another bitter fight over medical care legislation is forecast in California where Governor Earl Warren has again renewed his efforts to set up a state-wide system of prepaid medical insurance. A similar measure was defeated a year ago as the result of the active efforts of the California Medical Association. The Association is now faced with the fact that Governor Warren, reelected with the endorsement of both the Republican and Democratic parties, will be in a strong position to secure additional support for his proposal. The California Medical Association is expected to fight the measure on the ground that it would inject the State between the doctor and the patient, lead to deterioration of medical services, and that it would be, according to one source, a step toward socialization of everything. The Association favors voluntary systems of medical care such as its own California Physicians Service which has some 400,000 members, or about three times the number covered by it eighteen months ago when Governor Warren first initiated his proposals.

* * * * *

Our hats are indeed off to the State of Indiana where in the 85th Session of the General Assembly a resolution was passed which requests that Indiana's members in Congress vote "to fetch our county courthouse and city halls back from Pennsylvania Avenue (Washington)." "We want government to come home," stated the report, "and we call upon the legislatures of our sister states and on good citizens everywhere who believe in the basic principles of Jefferson and Lincoln to join with us and we with them to restore the American republic and our forty-eight states to the foundations built by our fathers."



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Edgewood Medical Secretaries are skilled in laboratory technique, medical stenography and accounting. Interested professional men should phone or write the Placement Office.

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Carbohydrates as protein sparers have particular significance in infant nutrition, which requires a high order of efficient utilization of protein for an active metabolism.

CARTOSE* is well tolerated; its content of dextrins in association with maltose and dextrose minimizes gastrointestinal discomfort due to an excessive concentration of readily fermentable sugars in the gastrointestinal tract.

CARTOSE is liquid, facilitating rapid, exact formula preparation. It is compatible with any formula base —liquid, evaporated, or dried milk.

SUPPLIED: In clear glass bottles containing 1 pt. Two tablespoonfuls (1 fl. oz.) provide 120 calories. Available through recognized pharmacies only.

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*The word CARTOSE is a registered trademark of H. W. Kinney & Sons, Inc.

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HOSPITALS IN THE POST-WAR WORLD*

CARLETON R. METCALF, M.D., RALPH W. TUTTLE, M.D.,
and RICHARD W. ROBINSON, M.D.

* A report to the Council of the New England State Medical Societies by the representatives to the Council from New Hampshire presented at a regular meeting at Boston, January 15, 1947.

WHILE many general hospitals now fail to provide various types of service and will not admit certain types of patients, their role is expanding. Eventually the general hospitals may care for communicable diseases, for certain types of tuberculosis, for nervous and mental ailments, for the convalescent patient and the chronic patient. Then they will become the focal points for health services in communities.

Acute Communicable Diseases: As methods for control have improved, there is less and less demand for special institutions. In a general hospital certain special facilities would be required. Nursing service would be more expensive, but would cost less than it does in a special institution. In a period of little or no communicable disease, the accommodations could be utilized for other patients. The public will have to be educated to accept this plan.

Pulmonary Tuberculosis: Many general hospitals refuse to take these patients, and special institutions will still be needed. Sanitoria may provide medical care; surgical care, e.g., collapse therapy, may revert to a general hospital with its completely equipped operating room. Proper isolation and proper nursing technique would be needed, and, for this type of patient, the general hospital might well be subsidized by state or county funds.

Further reduction in pulmonary tuberculosis will follow routine x-ray examination of all patients admitted to a general hospital. Early cases will be picked up. In a state with a low incidence, like New Hampshire, it is a question, however, whether the "pick-ups" warrant the expense.

The possibility of lessening or of eradicating the disease makes one question the desirability of building additional special hospitals in rural areas. It is often difficult to reach them, it is difficult to keep employee's in them, and it is difficult to get consultants for them.

Several years ago New Hampshire won the position of lowest tuberculosis death rate state east of the Mississippi River, despite the fact that it is one of the leading industrial states in the nation in proportion to its population (fifth). Our citizens are supposed to be farmers, but they are primarily industrialists.

Wyoming has the lowest death rate from this disease per 100,000 population: 9.3 (1945).

The New England States (also 1945) gave the following death rates from tuberculosis per 100,000 population:

New Hampshire	20.1	Vermont	33.5
Maine	20.5	Connecticut	35.5
Rhode Island	32.6	Massachusetts	39.1

We do not know the answer. It might be worthwhile for the Council to put this riddle on its agenda.

Nervous and Mental Diseases: The general hospital may provide facilities for patients with mild types in this group—for those who need not be committed and who do not require long-term care. Surgical aid and consultation should be available. This group also might have to be subsidized by the state or county.

Chronic Diseases: Patients in this classification are a problem and a growing problem. A general hospital is reluctant to accept them, but the trend is to place them in a separate unit adjacent to a general hospital. This unit should not be a home for the aged or for the permanently disabled, but a temporary refuge for those who have a reasonable expectation of returning home. There should be recreational facilities.

Long-term patients with little hope of recovery need a proper institution. Their care, at present, is often inadequate. There should be regulation of nursing homes to guarantee good service. The daily cost of caring for chronic patients is less than that for the acute type of illness, but a prolonged illness makes the total cost loom large.

The Convalescent Patient: The convalescent period in a general hospital is getting briefer, partly because of the shortage of beds, partly because of advances in medical science. Before the recent war five hospital beds were considered adequate for

continued on page 226

UPPER RESPIRATORY INFECTIONS:

management with PENICILLIN SCHENLEY

Both systemic and topical penicillin administrations have been found valuable in the treatment of infections of the mouth, nose and sinuses, pharynx, tonsils, larynx, and tracheobronchial system.[1, 2] Since respiratory infections often show a tendency to relapse, it is all-important to adhere to the principle established by clinicians widely experienced in penicillin therapy:

give enough-soon enough-long enough

(1) Menefee, E. E., Jr., and Atwell, R. J.: South. M. J. 39:726 (Sept.) 1946.
(2) Woodward, F. D., and Holt, T.: J.A.M.A. 129-589 (Oct. 27) 1945.



PENICILLIN SCHENLEY. Suggested dosage: Intramuscular, 20,000 to 40,000 units every three hours, continued until the patient has been symptom-free for forty-eight to seventy-two hours. Topical, instillation of 3 to 5 cc. of a solution containing 5,000 to 10,000 units per cc., repeated as frequently as indicated in the judgment of the physician.



PENICILLIN TABLETS SCHENLEY. Suggested dosage: 2 tablets (50,000 units each) every two or three hours day and night until all signs of infection have been absent for at least forty-eight hours. This treatment is suitably employed after initial parenteral therapy, and as an adjunct to topical administration.



Specialized skills devoted to the control of bioculture processes insure the dependability of all penicillin products bearing our label.

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SCHENLEY LABORATORIES SERVICES: 1. Penicillin Paragraphs for March, dealing with upper respiratory infections, has been mailed to all physicians. 2. A comprehensive penicillin dosage chart will be mailed to physicians on request.

NO. 9 in Schenley Laboratories' continuing summary of penicillin therapy

HOSPITALS IN THE POST-WAR WORLD

continued from page 224

each thousand of population; today, with these advances, four or four and one-half beds per thousand are probably sufficient. Twenty-five years ago an appendectomy required two weeks in a general hospital; childbirth required the same span.

We are probably coming to special pavilions for convalescents, where a program for rehabilitation might be offered. Assistance in dietetic and therapeutic care might even be given convalescents after they return home. Rehabilitation services in the Army have proved of material value in reducing the term of disability. Facilities and personnel for occupational and physical therapy are the rule in nervous and mental hospitals. An extension of such a program would tend to return handicapped persons as productive members of society.

Licensure of Hospitals: Licensure ordinarily covers mental and maternity hospitals, and in some states, hospitals for tuberculosis, but only six states have comprehensive legislation. Massachusetts is one of the six.

Supervision varies greatly. In some states there is a special hospital commission; elsewhere, the Department of Public Welfare or the Department of Health holds the reins. Usually there is no overall supervision. In New Hampshire we have considered overall supervision seriously, but each agency that now has a finger in the pie wishes to maintain its position.

However, it would be well to license all institutions that care for the sick and to concentrate supervision in one agency, which should have the advice of hospital administrators.

This agency might well be the State Board of Health. This Board would probably be strengthened by the inclusion of one or two laymen. Doctors are specialists and individualists and some of them are poor businessmen.

Hospital Trustees: The Board of Trustees should be composed of laymen and laywomen, who know something about the various phases of administration. The College of Surgeons says there should be no doctor on the Board. Nor should the Board be composed entirely of women.

There should be a definite liaison between the trustees, the staff and the administrator. In the hospital of one of us (C. R. M.) these three meet regularly twice a month. Matters pertaining to the staff are referred back to the staff for action.

Membership on a board of trustees should be a position of public duty and responsibility rather than of honor; but since it is sometimes a position of honor and since some trustees are rather slender reeds, it behooves a hospital to select a well-trained administrator. This is becoming a highly specialized field.

Nursing Service: Many hospitals have both graduate nurses, registered by the state, as well as pupil nurses and non-professional personnel. Special nurses may not be used as freely in the future as they have been in the past.

There is a growing movement to divide pupil nurses into two classifications:

1. The first group would have one or two years in college and then either three years as a pupil nurse or two years as a pupil nurse and one in postgraduate nursing. Such a curriculum might well warrant an A.B. degree. Skidmore, Bates, and very likely other colleges, are now offering this course.

2. A second group of high school graduates would have perhaps a year of training in conjunction with a professional nursing school. These would become "service nurses" or "practical nurses."

In other words, new emphasis will probably be placed on a broader educational background, which will discourage nursing schools in smaller hospitals. But we need more nurses. And we must recognize clearly two causes of the present nursing shortage.

1. Competition from the Veterans' Administration and from private industry.
2. Insufficient pay.

Unless we are ready to pay our nurses more it is a poor time to demand a "broader educational background."

As a matter of fact, wages for nurses have climbed a lot during the past year, and they are going still higher. Graduate nursing will become economically more attractive. A further problem now is to provide better schools of nursing and this, in part, is a problem for doctors. The doctors must put more energy into teaching the girls.

Incidentally, on the average, a girl practices her profession for only three years after graduation. Let's make it five years!

Offices in Hospitals: An increasing number of doctors have their offices in hospitals. An example of this sort in New Hampshire is the Mary Hitchcock Hospital in Hanover.

Group practice, which is also becoming more prevalent, may well provide medical care of higher caliber.

Size—Location—Type: Rural areas are not now thoroughly covered.

Rural hospitals should have offices for physicians; facilities for public health activities; diagnostic service and scheduled clinics. They should establish relations with a larger urban hospital.

Hospitals of less than fifty beds cannot be operated efficiently; nor are competent specialists likely to be available for them. Anything under fifty beds would better be a "health center."

continued on page 228



"Bronchial Asthma ...etiology undefined"

In the paroxysms of bronchial asthma neither the physician nor his patient can wait for full identification of all asthmagens. *Without delay, symptoms must be relieved.*

PARASMA provides this rapid, symptomatic relief by the *oral* route. It is a synergistic combination of three principal oral antiasthmatics recognized individually in the *United States Pharmacopoeia.*

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HOSPITALS IN THE POST-WAR WORLD

continued from page 226

A fifty-bed hospital requires a minimum of 15,000 persons living within a radius of not more than thirty miles.

For comprehensive medical service and efficient operation, a hospital should have from 100 to 750 beds, depending on the number of patients to be served. Too large an institution becomes impersonal.

The general hospitals carry 94 per cent of the load although they have only 50 per cent of the beds.

Cost of Hospital Care: The cost of hospital care is advancing and will doubtless continue to do so. In New Hampshire the Blue Cross has been a boon, not only to the patients, but to the hospitals. In our state the Blue Cross is now charging 85 cents per month for the individual, $1.70 per month for man and wife, and $2.00 per month for a family.

With increased membership in New Hampshire, we are now offering coverage to the individuals of a community who are not eligible for a group. We take everyone without restrictions. In Concord a month ago we had about 10,000 participants in Blue Cross. In a three-day community drive, we added 3,000 so that half the population of the city is now enrolled.

Eight New Hampshire hospitals have recently made or are making drives for additional funds for new construction. The sums asked for range from $50,000 to one million dollars. All are going over the top. An era of inflation is apparently the time to ask for money.

Public Health Centers: In an area which is too sparsely populated to justify a hospital, provide a public health and medical service center.

Such a center could offer:

1. Offices for physicians.
2. Health Education.
3. Public health and preventive medicine.
4. Routine laboratory tests.
5. Simple x-ray service.
6. Emergency treatment for accidents.
7. Normal obstetrical care with prenatal and postnatal observation.

Such a health center might well be a feeder for an urban general hospital. The center should cover a total number of people rather than an area. Federal funds, under the extension of the existing social security act, may be necessary. Or we may follow the Western idea of cooperative hospitals and health centers in sparsely populated areas, with the doctors on salaries.

Interrelationship: At present there is too little coordination among hospitals. Brattleboro, Vermont, covers a segment of New Hampshire; Springfield covers part of Connecticut; Hanover attracts patients from Vermont, and Portsmouth gets them from Maine. With coordination of the state plans, which are now underway, overlapping can be reduced to a minimum. This is particularly true in New England.

In smaller communities hospital service is often inadequate; in metropolitan centers there is unnecessary duplication.

We look for the development of hospital councils that will formulate hospital relationship on a regional or district basis, with liaison between districts and larger hospitals in urban centers. Witness the Bingham Associates in Maine and the Salem hospital in Massachusetts. A decision can be made whether the services of a large general hospital shall be carried to the small hospital or whether patients from a small hospital shall be transported. So far as possible, a patient should stay in an institution near his home. We envisage, in short, "horizontal medicine."

We suggest then the following trend in hospitalization in the post-war world:

1. Expansion of the general hospital, with increasing acceptance of communicable diseases, of certain types of tuberculosis, of nervous and mental ailments and, perhaps in separate pavilions, of care for patients in the convalescent and chronic stages.

2. Increasing subsidies from the federal government, the state or the county. The Hill-Burton bill provides a subsidy. For "relief" patients the government under its different programs pays only about 50 per cent of the actual cost of medical care. The government should pay the entire cost for the individual so classified.

3. Extension of physical and occupational therapy.

4. State licensure for all institutions that care for the sick, supervised, we hope, by one agency.

5. Responsible boards of trustees who will cooperate with the medical staff and with a sure-fire administrator who has his feet on the ground.

6. Two groups of nurses, besides the graduates. The first group with better background and a longer training period; a second group for the simpler tasks with briefer training.

7. Higher wages for nurses and for all hospital personnel. The American Hospital Association is working on the problem of pensions. Social Security does its part, but it should be furthered by a fund contributed by the hospital and the employees themselves.

8. An increase in the number of doctors who have their offices in hospitals and an increase in group practice.

continued on page 230



The sick or injured patient is almost simultaneously subjected to two traumas—the basic pathologic process and tissue malnutrition—for malnutrition almost always begins "as soon as injury or disease occurs."[1] Recognition of the vitamin depleting role of dietary restrictions, increased metabolism, glucose infusions, and impairment of absorption, has brought with it the realization that vitamins must be administered in therapeutic—not maintenance—dosages when multiple deficiencies complicate disease. Upjohn provides a full range of maintenance and therapeutic vitamin preparations for oral and parenteral administration.

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HOSPITALS IN THE POST-WAR WORLD

concluded from page 228

9. A gradual increase in the cost of hospital care which will be materially alleviated by insurance plans.

10. Public health centers in areas of scanty population, rather than an increase of small hospitals.

11. Closer coordination among hospitals, perhaps under the sponsorship of hospital councils.

RALPH W. TUTTLE, M.D.
RICHARD W. ROBINSON, M.D.
CARLETON R. METCALF, M.D.

ROLE OF MEDICAL RECORD LIBRARIAN

concluded from page 199

members of the staff wear gauze masks while in contact with the children during the winter months.

Qualitative Analysis of Infections:

A medical records librarian gives the most assistance in this regard by completely listing hospital infections on the monthly analysis and giving the numbers of a selected few cases which warrant investigation. From this information, the chief of service for each department has a basis for comparison of statistics and for review of causes at regular intervals.

Report of Adjunct Departments

For Clinical Laboratory reports, the number of urinalyses, blood examinations, blood chemistries, tissue reports, etc., may be entered daily. This same procedure may also be carried out in the departments of Radiology, Physical Therapy, Electrocardiography, Occupational Therapy, etc. If these figures are totalled monthly and yearly, the administrator and his assistants will have an analysis of the total work being carried out by each department.

The medical records librarian in keeping a record of the monthly analysis contributes a great deal towards the accurate appraisal of efficiency of the hospital.

VA MENTAL HYGIENE CLINIC

The 14th of October, 1946, marked the opening of the Veterans Administration Mental Hygiene Clinic, located in the old high school building on Hope Street, Providence. The aim of the Clinic is to treat eligible veterans for neuroses on an Out-Patient status. Examination for purpose of diagnosis, pension determination and hospitalization is performed in the Neuropsychiatric Hospitalization-Examination Section of the Medical Division.

The Staff of the Mental Hygiene Clinic at present includes one full-time psychiatrist, Dr. J. M. Zucker, and six attending, Drs. V. Behrendt, M. W. Finlayson, S. S. Goldstein, G. L. Muller, L. A. Senseman and C. Zouraboff. All techniques are in use except for formal psychoanalysis and group therapy. It is planned to begin group therapy in February, 1947. There are two full-time social workers—Mr. A. Leader, Case Supervisor, and Mr. A. Stone. Two full-time psychologists are in the process of selection.

Cases may be self-referred, referred by outside physicians and agencies or from Veterans Administration Out-Patient Department and other sections of the Veterans Administration. Social Service Intake evaluates and orients patients on initial contact. After this, interviews are by appointment only and adjusted to the convenience of the patient if he is employed, in training or in school. At present, there are four night clinics a week but only for psychiatric interviews. Fee basis psychiatrists and contract clinics supplement the Mental Hygiene Clinic facilities.

Psychiatric conferences for professional personnel are held weekly. In 1946 these were from 3:00 to 4:30 P. M. on Wednesdays. This time was not convenient for Veterans Administration staff members; therefore, in 1947, such conferences are taking place from 8:15 to 9:00 A. M. each Tuesday morning. Professional visitors are welcomed to these conferences where discussion and criticism are expected.

Inquiries may be directed to Mr. Leader (GAspee 3475, Extension 152) or to Dr. Zucker, Chief of the Clinic.

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to combat persistent depression in the aged patient

Old age sometimes brings a severe and lasting depression, marked by self-absorption, withdrawal from former interests and loss of capacity for pleasure. This depression often aggravates underlying pathology by interfering with exercise, appetite and sleep.

Because of its power to restore mental alertness and zest for living, Benzedrine Sulfate helps to overcome depression and anhedonia in the aged. Obviously, careful observation of the aged patient is desirable; and the physician will distinguish between the casual case of low spirits and a true and prolonged mental depression. The dosage should be adjusted to the individual case.

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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

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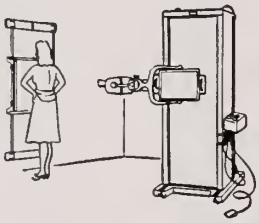
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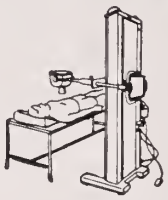
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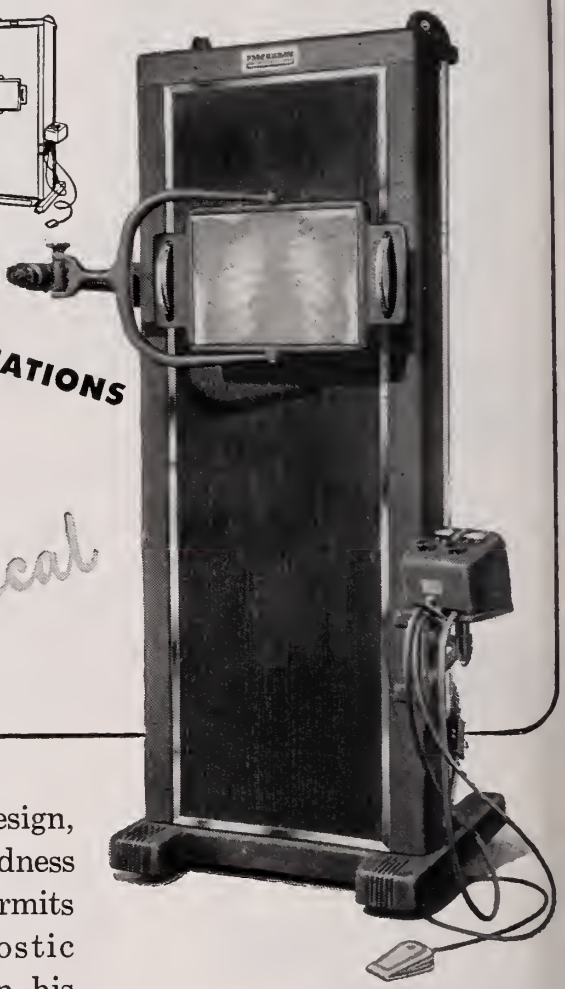


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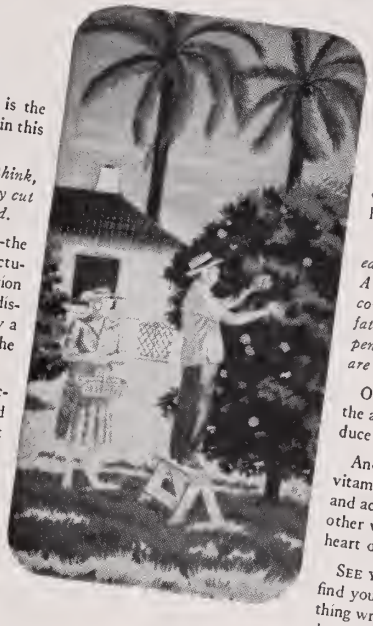
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A common type of heart disease—the so-called "functional" type—is not actually heart disease at all. It is the reflection of some other, usually correctable, disturbance in the body. It is often merely a temporary condition. It does not alter the heart itself, nor does it shorten life.

Even "organic" heart disease, which actually changes the heart's structure, need not be a serious disability. The handicap it imposes on a normal life will vary widely —with the nature of the disease and the individual case.

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Two men may have identical symptoms. One man's heart condition may dictate a careful limitation of his activities. The other man may be able to live a normal life span with only slight restrictions on his way of living.

Medical science during the past few years has made great progress in understanding the nature of heart disease, and in developing new methods of prevention and treatment.

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There is, for instance, a kind of heart disease known as subacute bacterial endocarditis. A few years ago doctors were helpless in combatting what was practically always a fatal infection. But now, through the use of penicillin, an increasing number of cases are being successfully treated.

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Volume XXX, No. 4

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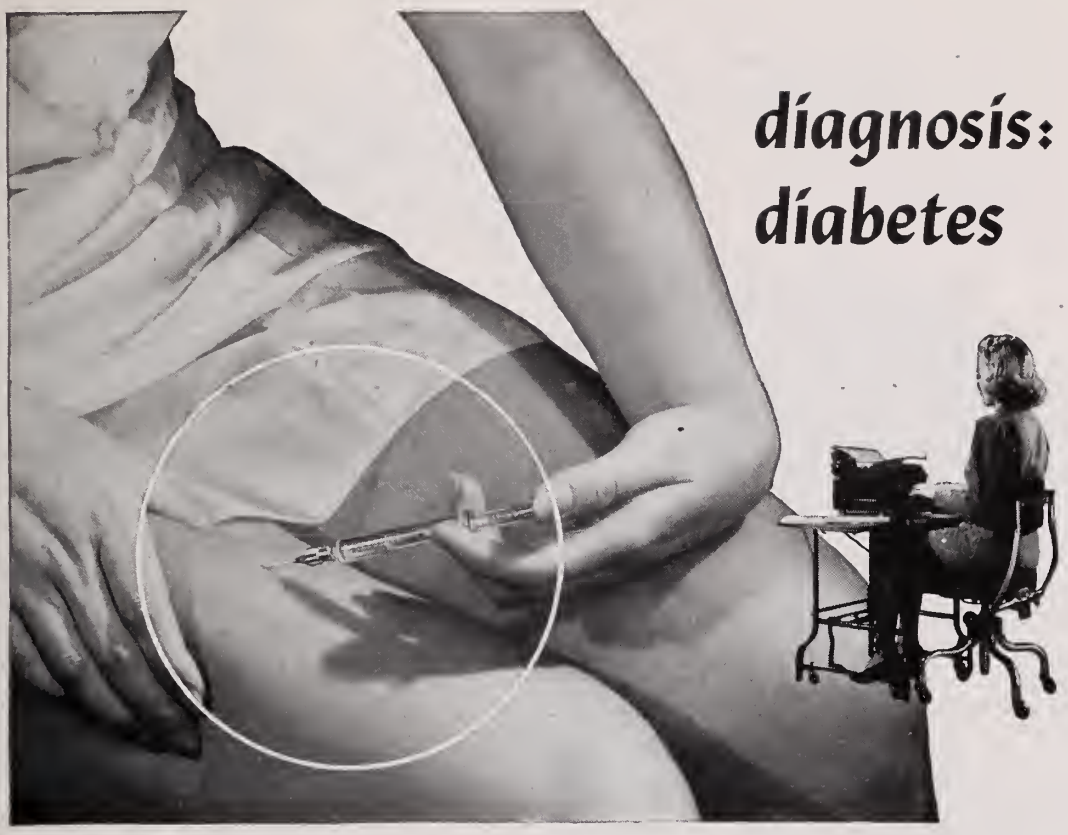
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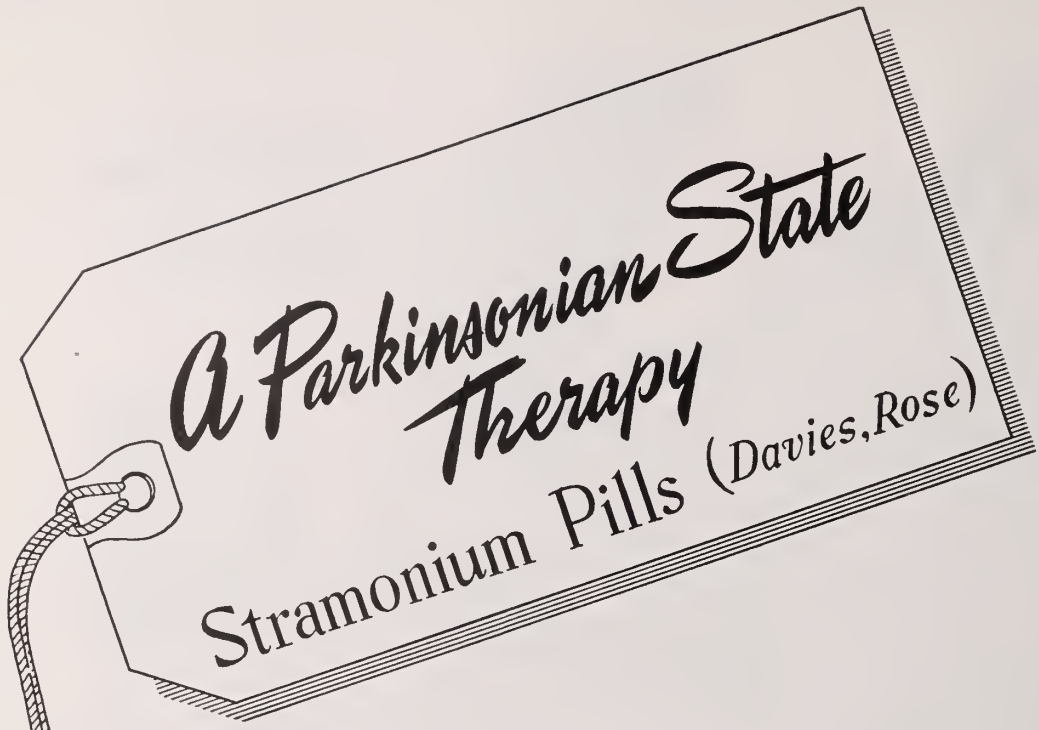
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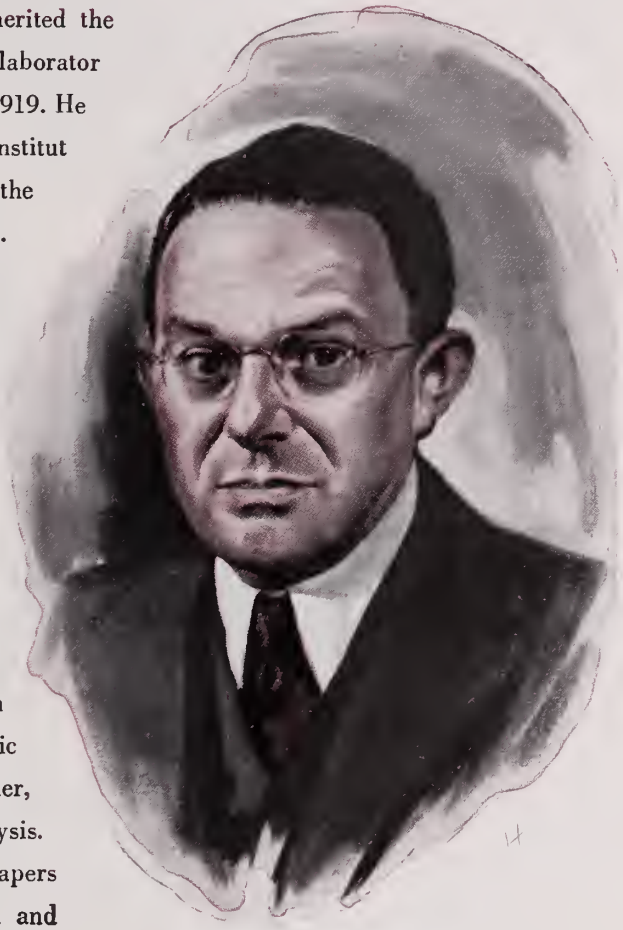
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Men and Amino Acids

Max Bergmann may be said to have inherited the mantle of Emil Fischer, whose principal collaborator he was at the time of the latter's death in 1919. He became Director of the Kaiser Wilhelm Institut für Lederforschung and, later, Member of the Rockefeller Institute for Medical Research. In 1925 he identified the dehydropeptides, substances of physiological interest which serve as substrates for a highly specific enzyme system. His "carbobenzoxy method", announced in 1932, provided a new, elegant technique for the synthesis of peptides. This led to the proposal of a system for step-by-step degradation of polypeptides, permitting successive removal and identification of individual amino acids. His investigations on protein structure and the specificity of proteolytic enzymes fostered the development of finer, more precise methods of amino acid analysis. Bergmann's more than 300 published papers contributed brilliantly to modern protein and carbohydrate chemistry, which are part of the foundation on which medical science rests.



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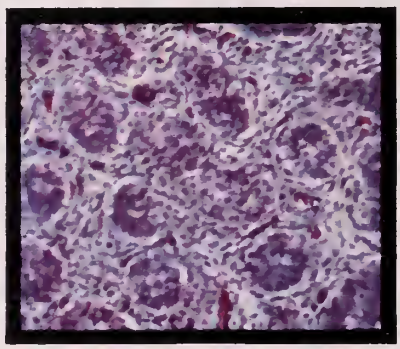
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1. Thompson, W. O.: J.A.M.A., 132: 185, 1946.

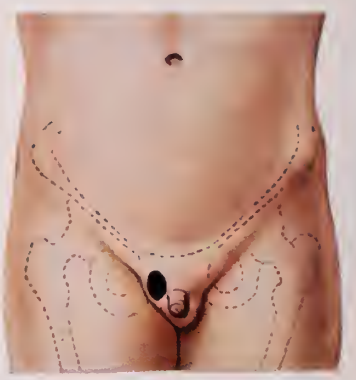
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MALPOSITION OF THE TESTICLE

Right obdominol testicle. Three positions of the undescended testicle in the obdomen.

Right pubo-scrotol testicle. Position of the undescended testicle in the pubo-scrotol region.



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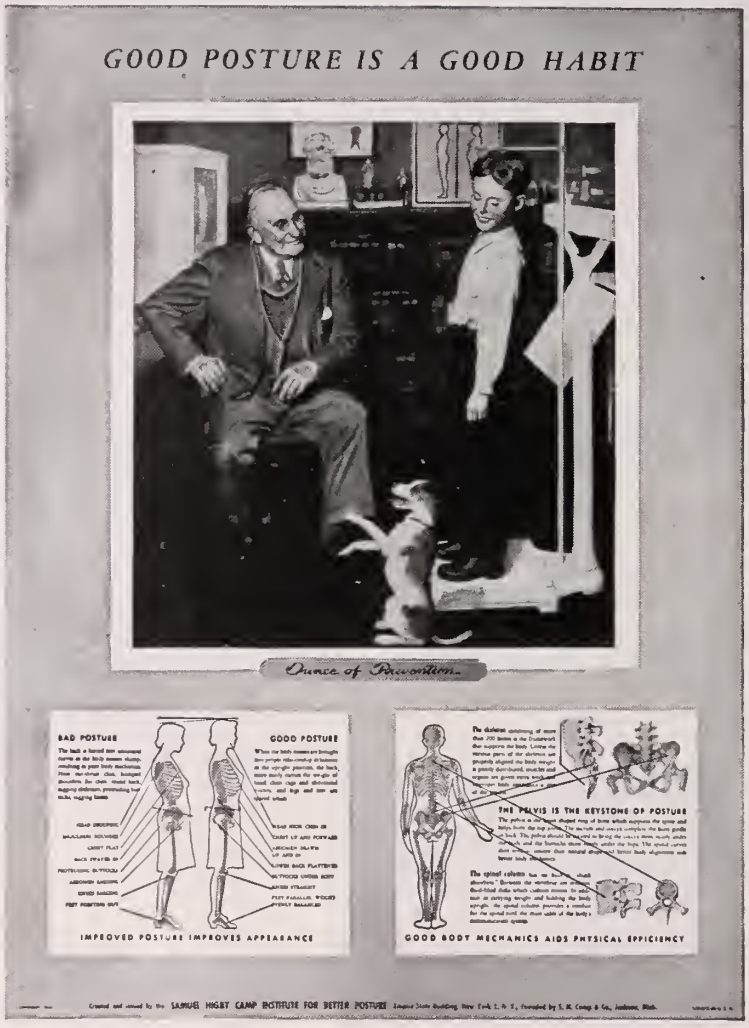
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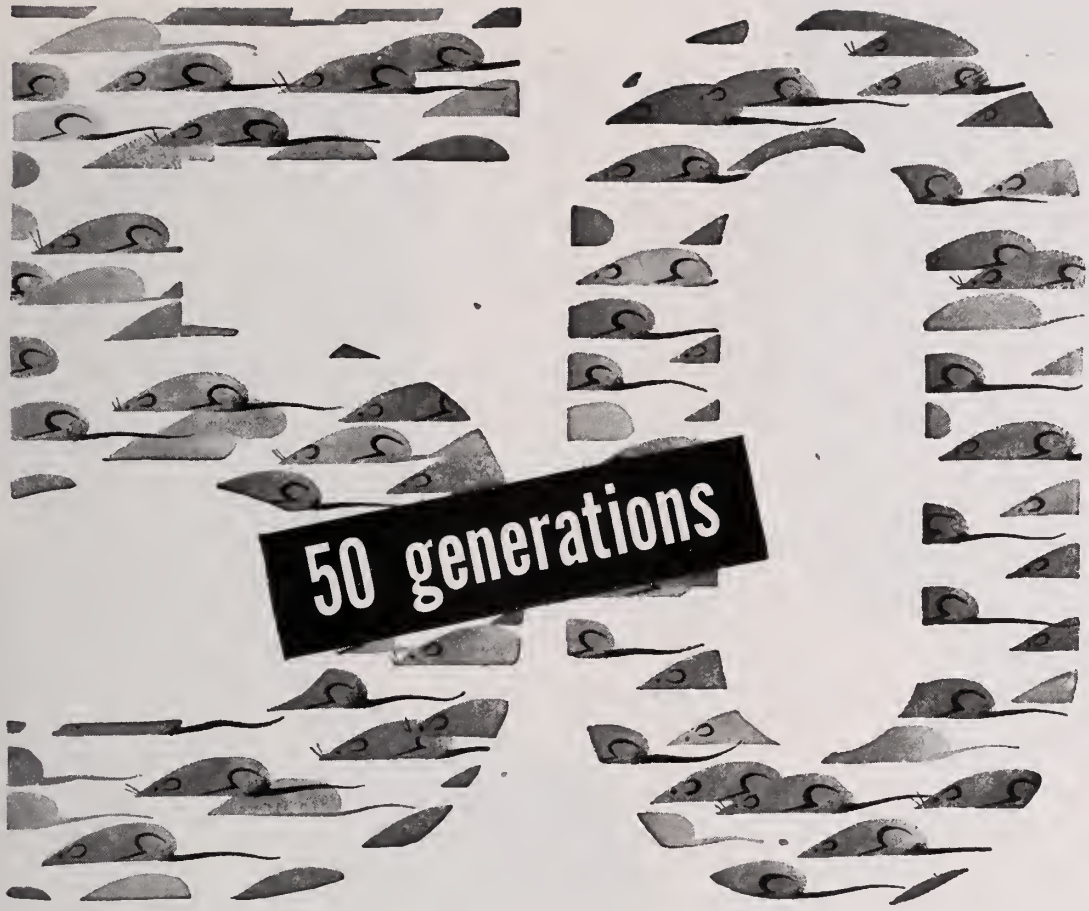
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1. National Research Council Bull. No. 109 (Nov.) 1943, p. 36.
2. Southern M. J **3**:172 (Feb.) 1946.
3. Statistical Bull. Metropoliton Life Ins. Co. **27**:6 (Dec.) 1946.

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XERODERMA PIGMENTOSUM*

F. RONCHESE, M.D.

The Author. *Francesco Ronchese, M.D., Dermatologist-in-chief, Rhode Island Hospital; Instructor in Dermatology, Boston University School of Medicine.*

IN 1870, Kaposi gave the name *xeroderma pigmentosum* to a rare disease of the skin which appears in infancy or childhood in one or more members of the same family, whose parents are often related. The condition is so peculiar that about 460 cases have been reported in the world literature, according to Macklin.[1]

The dermatosis is located on those parts of the body which are exposed to light (face, neck, arms, legs). It begins with the appearance of freckle-like spots, which become increasingly pigmented, until some are as black as ink. The exposed parts of the skin and mucous membranes (lips and eyelids) become dry and scaly, with telangectases and keratoses, similar clinically to those seen in roentgen ray dermatitis.

The occurrence of this pathology in an infant or juvenile face, gives it the appearance of premature senility[2] similar to that seen in the skin of the aged, the farmer, fisherman or sailor, who have been exposed to the direct action of the sun's rays, for the greater part of their lives.

Xeroderma pigmentosum is a photosensitization dermatosis, the affected person being sensitive to the radiations of the sun and particularly to the ultraviolet rays. Investigators have experimentally exposed small areas of apparently normal skin, in patients with xeroderma pigmentosum, to roentgen and ultraviolet rays, and have proved this hypersensitivity, which has manifested itself by an exaggerated inflammatory reaction and, secondarily, with hyperpigmentation.[3]

* Read at the Meeting of the New England Cancer Society, at Providence, R. I., November 6, 1946.

The keratoses progress to epitheliomas, of the squamous, basal or mixed type, as in the sailor, the fisherman or the aged. When cutaneous carcinomas develop, usually, the life expectancy is short. Within 5 or 6 years the patient dies of generalized carcinomatosis.

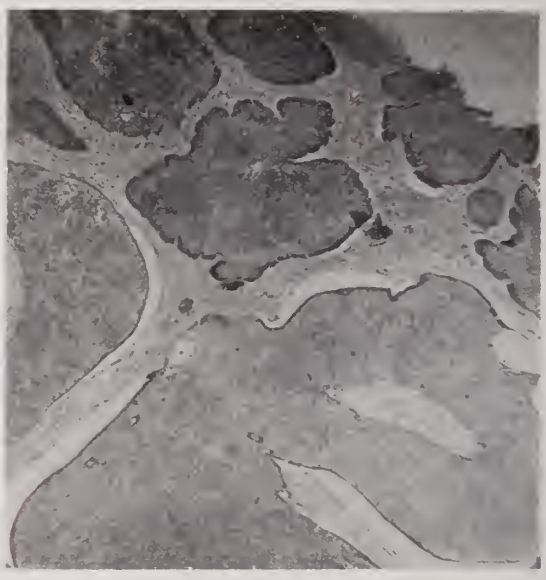
Case Report

"A 25 year old, single, white woman, of Italian ancestry, living on a farm, was seen in my office on May 7, 1943 and later in the department of Dermatology and in the Tumor Clinic of the Rhode Island Hospital. She was the oldest of 9 children, all apparently well. There was no known incident of the disease in the parents, relatives or ancestors. The parents were third cousins. The patient's condition became progressively worse during the past 10 years, and she decided to seek medical care after a large keratose on her face became ulcerated and a tumor 5 by 2 inches developed under the skin of her left leg. An important factor in her past history was that a physician administered ultraviolet air cooled therapy for a period of 6 years. With this exception, no other medical attention was given, until the keratose on the face became ulcerated, and the large tumor developed on the leg. A general physical examination was negative. Blood and urine were normal. A psychometric test showed a fair general level of intelligence.

As in all cases of xeroderma pigmentosum the patient showed a severe cheilitis and conjunctivitis. However, while the lower eyelids were severely involved with almost total loss of eyelashes, the upper eyelids were of normal texture and with normal eyelashes. On the exposed parts (face, neck, chest, shoulders, arms, lower legs) there were areas of hyperpigmentation varying in size from the head of a pin to a quarter, of all shades from light brown, sepia, deep brown to ink-black. Interspersed

continued on next page





Typical clinical features of xeroderma pigmen osum. Marked senile dryness of facial skin and mucous membranes. Telangectases, spots of hyperpigmentation of various sizes and shades from light brown to ink black, keratoses, multiple basal cell epitheliomas. At right, low power mycrophotograph of ulcerated basal cell epithelioma of the cheek.

among these were telangectases, keratoses and pinhead or pea-sized, pearly, basal cell epitheliomas. On her left zygomatic region there was an ulcerated basal cell epithelioma (rodent ulcer) the size of a quarter. All over the face, neck, chest, shoulders and lower legs were scattered pearly, nodular, pea-sized tumors with telangectases, all having the same clinical appearance of pigmented basal cell epitheliomas.

The ulcerated tumor of the left zygomatic region proved pathologically to be a basal cell epithelioma and was treated with radon implants with perfect result. The tumor of the leg as well as many others, removed from the skin of the legs and arms, proved to be malignant melanomas. Some were removed surgically, others were coagulated with high frequency current. All areas treated healed up perfectly with no evidence of recurrence up to this date. A large number of very small lesions about the face were coagulated under intravenous anesthesia with satisfactory result. The last time the patient was seen she was gaining weight, was gay, busy and completely unconcerned about the appearance of her skin and her uncertain future. In fact she was engaged and planning to get married.

However, although the treated areas showed no sign of recurrence, many new growths had developed, some black and crusty, some fungating and pedunculated."

Comment

While many dermatological conditions are the object of endless discussion before agreement is reached, if it is reached at all on the diagnosis, fully developed xeroderma pigmentosum offers no diagnostic difficulties. Only at the very beginning the infantile lesions may be called freckles and the very mild adult cases, dry skin. Very early, the infantile skin becomes prematurely mature, and later, prematurely senile[2] and the diagnosis of xeroderma pigmentosum is no more questionable.

The correct diagnosis, however, is not so obvious outside the dermatological field. The student goes out of medical school with a vague idea of it from the text books and some lecture and quickly forgets it. The case confirms this point. While it is known that lupus erythematosus, hydroa vacciniformis, xeroderma pigmentosum are definitely due to a peculiar sensitivity to the ultra violet part of the solar spectrum, this patient received ultra violet air cooled therapy for six years.

Another interesting feature of this case is the demonstration of the curability of basal cell epitheliomas by curettage and high frequency coagulation or dessication, without radiation or surgery, if properly, which means thoroughly, done. This is no novelty, of course. Many series of cases have been reported in which this point was demonstrated.

At the meeting of the American Academy of dermatology, in Cleveland, December 1946, Guequierre showed a long series of cases of various sized basal cell epitheliomas observed for 5 or more years, cured by high frequency coagulation and no radiations or surgery.

In the present case the face, and particularly the

eyelids and lips, were all covered with pin-head to pea-sized basal cell epitheliomas. Surgery could not be used and radiations were to be avoided, if possible. All were treated by high frequency coagulation under intravenous anesthesia and all healed up nicely with no sign of recurrence to date.

Summary

Cases of xeroderma pigmentosum are rare and always interesting. A peculiarity in this one is the tolerance of this intelligent young woman to such an extensive facial disfigurement.

In spite of a large number of epitheliomas and malignant melanomas, the therapeutic result has been very good. All lesions have healed promptly without unsightly scars and with no evidence of metastasis up to the present time.

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170 Waterman St., Providence 6, R. I.



The characteristic distribution of the dermatosis with no lesions on the so-called bathing suit area.

Notice the very good feminine body build and the good result of the surgical removal of the malignant melanoma from the left lower leg.



Malignant melanoma of left leg surgically removed

VA MENTAL HYGIENE CLINIC

In the March issue of the JOURNAL the statement was made that the U. S. Veterans Administration Mental Hygiene Clinic at the old Hope high school building in Provdence would hold staff conferences, open to professional visitors, on Tuesday mornings. The new schedule since announced calls for these conferences on Thursday mornings from 8:15 a. m. to 9 a. m.

MEDICINE IN THE TIME OF THE CRUSADES

ROLAND HAMMOND, M.D.

The Author. *Roland Hammond, M.D., of Providence. President of the Rhode Island Medical Society, 1935-36.*

To the average man the history of the Crusades is a thrillng romance. Responding to an intense religious emotionalism, coupled with avarice or love of adventure on the part of some, enormous surges of people trudged wearily thousands of miles, or made an equally hazardous journey by sea to achieve an impossible ambition. Then followed the equally weary retreat, and the remnant of a once proud band, their heraldic emblems besmirched, and they themselves impoverished, sick at heart and in body, gradually sifted back to their home towns.

But it had been a great experience—the first Cook's tour. Many of the peasant class had never before journeyed beyond the confines of their birthplace. For the first time in their lives most of these thousands of people, men and women, had tasted the delights of travel. Many of them had never before experienced a hot climate. They tasted strange and delicious food, especially fruits and spices; they were impressed by an older, more stabilized and more leisurely civilization. They were ill, and consulted the physicians of the Arabian school, who administered an entirely different, and it is to be hoped a more agreeable form of treatment, than that to which they had been accustomed in Western Europe.

Many of us, as boys, had our first glimpse of the history of the Crusades, when our imaginations were fired by reading Sir Walter Scott's *Talisman*. Clearly outlined in my memory, as I am sure it is in your own, is the description of the illness of King Richard the Lion Hearted, which had baffled the English leeches, but which readily yielded to a potent sleeping draught administered by the Arabian physician, El Hakim, who later revealed himself as Saladin, Richard's arch enemy, but a gallant soldier and a courteous gentleman.

Such was the conception a hundred years ago of the supposedly vast changes wrought in Western European civilization by its contact with the peoples of the Eastern Mediterranean during the Crusades. Unfortunately the modern historian attaches very little value to the Crusades as a factor in promoting intellectual or spiritual uplift. They were only one phase, and that not the most important, of the life of a vigorous epoch. They brought East and West into closer contact, stimulated trade, transportation and the use of money, and helped to accelerate many tendencies already at work, but their specifically intellectual consequences are less tangible and probably less significant.

The former conception of the Dark Ages as a period in which learning stood still, must be given up. Progress was constant and encouraging. In the early middle ages we see the formation of nations, the beginnings of our common law, the development of monastic life and the building of cathedrals, and the evolution of national languages, particularly English. The later middle ages are notable for the perfection of Gothic architecture, the establishment of large universities and hospitals and the growth of art.

The mediaeval period is characterized by several minor revivals of learning—the Carolingian Renaissance of the ninth century, the Ottonian Renaissance, neither of which helped to advance the science of Medicine, the Mediaeval Renaissance of the Twelfth Century, and culminating in the Thirteenth Century, which Dr. James J. Walsh considers the greatest of centuries. The revival of the Twelfth Century was devoted to philosophy and science, while the Italian Renaissance was distinctly a literary revival.

The period of the Crusades is generally considered to embrace the years from 1096 to 1272. In considering the status of medicine during this epoch we must note the progress of the science during the twelfth and thirteenth centuries.

During the earlier centuries of the middle ages, science and learning sought refuge in the bosom of the church and there grew up a period of monastic medicine characterized by a cult of faith healing or theurgic therapy, an implicit belief in the miraculous healing power of the Saints and of holy relics. Supernatural aid came to be more and more esteemed as the medical art showed itself to be helpless particularly in the time of the great epidemics. But the church soon saw the error of its ways when the clerics were devoting their time to medical prac-

tice and seeking fees, which should have been employed in strictly religious duties and placed a ban on the treatment of the sick by the clergy or monastic orders. These edicts were aimed not so much at medicine as at its malpractice by monks.

The time was now ripe for the intellectual revival of the twelfth century. At no point is it more marked than in the domain of science. The important fact for our purpose is that by the eleventh century Salerno had become the chief medical centre with the earliest medical school in modern Europe. It had become a seat of the healing art in the tenth century and by the eleventh century its school was well established. By the twelfth century Salerno had a medical literature of its own. This was primarily a literature in Latin, for in this century the common language of Western Europe was Latin. The twelfth century saw the full recovery of the medical literature of the Greeks and the translation of the more important works of the Arab physicians. Greek medicine, it is true, had never wholly disappeared from the South of Italy, where Cassidorus had created his library in the sixth century, and where certain Latin versions of Greek medical writers can be traced in Beneventan* copies as early as the tenth century—a meagre tradition but apparently enough to start the medical school of Salerno. Just when or how this centre of learning came into being no one knows, except for the fact that in the South of Italy the ancient tradition was most alive, and here far into the middle ages Greek was understood. The versions of Constantine the African, who was known as "that new and shining Hippocrates", developed though they did not start, the activity in the school.

The Salernitan masters dealt with many matters in medicine and surgery, as can be seen in their recently published works. Although like the Arabs, they avoided dissection of the human body, they have left a treatise on the anatomy of the pig, whose body in many characteristics most nearly resembles the human. Their writings on pharmacology and diseases of the eye were widely used. In general they emphasized bathing and diet—the baths of Salerno and other warm springs of the region were famous even in verse—and simple, sensible remedies. Their therapy was later popularized in a poem of 362 lines, the *Regimen Sanitatis Salernitanum*, some of whose maxims are still in circulation: viz: "After breakfast walk a mile, after dinner rest a while", etc. A more adequate statement of the early teaching of Salerno appears in the various versified treatises of Gilles de Corbeil, who came from the schools of Salerno and Montpellier to Paris to be physician to Philip Augustus and possibly to exercise some influence on medical teaching in the university.

While the revival of medicine in the West and the reestablishment of the medical profession proceed in the first instance from early Salerno, further advance in medical science required the full assimilation of the medical knowledge of the ancient world, particularly the works of the father of medicine, Hippocrates, and those of his voluminous successor, Galen. Something of their teaching had come from the Arabic through Constantine of Africa, whose versions still make up the larger part of the twenty-six treatises composing the medical library of the Bishop of Hildesheim in 1161; but the great majority of their writings were brought to the West in the later twelfth century, partly from the Greek by the Pisan Burgundio, but chiefly through the Arabic of Gerard of Cremona.

These were supplemented by Arabic commentaries and adbridgements like those of Ali-ben-Abbas and the Jew Isaac, some of which were translated into German before 1200, and towards the close of the century by the *Canon* of *Avicenna*, which remained until our own time the standard cyclopaedia of medicine for the Mohammedan world. We have here substantially the body of mediaeval medicine, from which the university curriculum usually selected for concentrated study the *Aphorisms* of Hippocrates, the *Tegni* of Galen, the *Pantegni* of Ali-ben-Abbas, the works of Isaac the Jew, and, later, Avicenna,—the Arabian Galen. Fundamentally Greek, it had been enriched by much fruitful observation of diseases and their medicines among the Arabs.

Unfortunately, the scholastic habit of mind and the mediaeval reverence for the written word put these texts into a position of absolute authority, to be expounded and interpreted literally and dogmatically rather than experimentally in laboratories or clinics, after our modern fashion, so that medical science advanced very slowly in the period which immediately followed. In the middle ages it was considered that the proper method of arriving at sound knowledge was to argue the question, and never attempt to reach a conclusion by experiment. From the class rooms of the fourteenth century as they are depicted on the Bolognese monuments with the textbook lying open before master and student, it is a long way to Rembrandt's "Lesson in Anatomy".

On account of their rarity the gift of books to a mediaeval universty was equivalent to the bequest of a large fortune in our day. In the fourteenth century there were only nine medical books in the University of Paris.

Nevertheless, dogmatic and academic as was the study of medicine in the mediaeval university, some progress seems to have been made toward a saner

continued on next page

* *Beneventan was a peculiar Southern Italian hand found chiefly in the library of the Monastery of Monte Cassino.*

practice of the art. In the early middle ages there was no professional class of physicians as we understand the term, for the usual practice consisted in the domestic applications of incantations, charms and old wives' remedies of every sort.

Now if the school of Salerno was not wholly scientific in the modern sense, its treatment was at least simple and sensible, while the Arabs showed much skill in the actual healing of diseases and their practice gradually spread with the growth of the medical profession. Moreover, Jewish and Arab physicians were in great favor when they could be had; Henry I of England is said to have employed a converted Jew, Petrus Alphonsi, as well as a Christian named Grimbald, while in Spain the life of the Catholic princes was intrusted to the skill of the Saracens. The contrast between oriental skill and the old Christian superstition is instructively brought out in the narrative of a Syrian physician, Thabit, preserved in the memoirs of Usama:

They brought me a knight with an abscess in his leg, and a woman troubled with fever. I applied to the knight a little cataplasm; his abscess opened and took a favorable turn. As for the woman I forbade her to eat certain foods and I lowered her temperature. I was there when a Frankish doctor arrived, who said, "This man can't cure them!" Then, addressing the knight, he asked, "Which do you prefer, to live with a single leg, or to die with both of your legs," "I prefer," replied the knight, "to live with a single leg." "Then bring," said the doctor, "a strong knight with a sharp axe." The knight and the axe were not slow in coming. I was present. The doctor stretched the leg of the patient on a block of wood, and then said to the knight, "Cut his leg off with the axe, detach it with a single blow." "Under my eyes, the knight gave a violent blow, but it did not cut the leg off. He gave the unfortunate man a second blow, which caused the marrow to flow from the bone, and the patient died immediately.

As for the woman, the doctor examined her and said. "She is a woman with a devil in her head, by which she is possessed. Shave her hair." They did so, and she began to eat again, like her compatriots, garlic and mustard. Her fever grew worse. The doctor then said, "The devil has gone into her head." Seizing the razor he cut into her head in the form of a cross and excoriated the skin in the middle so deeply that the bones were uncovered. Then he rubbed her head with salt. The woman, in her turn, expired immediately. After asking them if my services were still needed, and after receiving a negative answer, I returned, having learned from their medicine matters of which I had previously been ignorant.

Occasionally one finds a startling bit of anticipation of what is most modern in medicine as well as in surgery. Toward the end of the thirteenth century, Gilbert the Englishman, teaching at Montpellier, insisted that the rooms of patients suffering from smallpox should be hung entirely with red curtains since it caused the disease to run a lighter course, with lessened mortality and with less disfigurement. At the end of the nineteenth century, Finsen demonstrated that the admission of only red light to the rooms of smallpox paients modified the disease, shortening its course, often prevented secondary fever, and almost completely did away with disfigurement.

A startling illustration of the neglect of surgery is to be found in the late appearance of artificial limbs, which were known to Herodotus and Pliny. On the other hand spectacles were known and used in the later middle ages.

The school of Salerno was soon followed by others at Montpellier, Padua and Bologna. In medicine, Italy indeed led the world. The improvement of the medical profession was further aided by the rise and growth of the great mediaeval universities in the twelfth and thirteenth centuries. These institutions attracted students often times to the number of ten to thirty thousand each. The earliest universities were established in Paris, Bologna, Oxford, Montpellier and Valencia, and in Italy at Padua, Messina and Naples. Roger II of Sicily, helped to raise the standard of medical education by forbidding anyone to practice medicine without proper examination, and his grandson, the generous and liberal minded Hohenstauffen Emperor, Frederick II, issued an edict requiring a candidate for license to practise to be examined in public by the Masters of Salerno. The candidate must have studied logic for three years, medicine and surgery for five years, and have practised for one year under some experienced physician. He insisted that surgery should occupy as long a course of study as medicine and should be founded on anatomy "without which no operator can be successful". For that age, it would be difficult to improve upon the plain scope and intention of this law. Frederick's edict did much to improve the status of the respectable physician and correspondingly to diminish the number of quacks.

The principal outcome of the School of Salerno was the work of two surgeons, bearing romantic names, Roger of Palermo, and Roland of Parma, whose writings were independent of Arabist sources. Roger's work became a standard textbook at Salerno, where he was a teacher. He recognized cancer and possibly syphilis, prescribed ashes of seaweed (iodides) in goitre, mercurial salves in chronic dermal affections, introduced the seton and suture of the intestines over a hollow tube, taught the use of styptics, sutures and ligatures in hemorrhage and the healing of wounds by second intention (laudable pus). Teodorico Borgognoni, Bishop of Cervia, disputed this doctrine. "It is not necessary," he says, "for pus to be generated in wounds". This simple statement makes Theodoric one of the most original surgeons of all time, for only Mondeville, Paracelsus and Lister upheld these principles after him. At this period that mediaeval substitute for anesthesia, the spongia somnifera, was introduced. The sponge was steeped in a mixture of opium, hyoscyamus, mul-

berry juice, lettuce, hemlock, mandragora, and ivy, dried and when moistened, inhaled by the patient, who was subsequently awakened by applying fennel juice to the nostrils.

The ablest Italian surgeon of the thirteenth century was Saliceto, educated in hospital and on battlefield, professor of Bologna and author of a Surgery in which surgical diagnosis and internal medicine were not separated, as was the common practise and the crying evil, as well, of this age. His pupil, Lanfranchi, became the founder of French surgery. His work on brain injuries and fracture of the skull is considered a classic. Lanfranchi's contemporary and loyal follower, Henri de Mondeville, was a hardy and original thinker who made a valiant plea for the principle of avoiding suppuration by simple cleanliness as originally taught by Hippocrates. His writings are rich in mother wit and biting sarcasm as illustrated by some of his sayings: "God did not exhaust all His creative power in making Galen". "Many more surgeons know how to cause suppuration than to heal a wound." "Never dine with a patient who is in your debt, but get your dinner at an inn. Otherwise he will deduct his hospitality from your fee". As Allbutt says, "It is hard to say when Henry is serious, when ironical and when mediaeval". The best known of the English medical men of this period were Bernard de Gordon, a teacher at Montpellier, Gilbertus Anglicus, and John of Gaddesden, supposed to be the original of Chaucer's Doctor of Physic. Guy de Chauliac, sometimes called the father of surgery, lived later than the scope of this paper. A few of the Popes were physicians, notably John XXI, sometimes called the ophthalmic Pope, because of his noteworthy writings on diseases of the eye.

Towards the end of the thirteenth century Mundinus of Bologna, revived interest in human dissecting, and his *Anathomia*, really a little hornbook of dissecting, was the sole textbook on anatomy for over a hundred years in all the mediaeval schools. In regard to the bull, *De Sepulturis*, issued by Pope Boniface VIII in 1300, which many supposed to have put a damper on anatomic research, it is shown by Neuberger and Walsh that it was, in intention at least, a simple mandate to prevent the bodies of dead crusaders from being boiled and dismembered, before returnng them to their relatives.

In this century internal medicine was essentially scholastic and monastic, that is, its votaries were either monks or schoolmen of the type of the foremost intellectual leaders,—Roger Bacon, Thomas Aquinas, Duns Scotus and Albertus Magnus. These writers were Arabists because of their unswerving fidelity to Galenic dogma as transmuted through Mohammedan sources. Peter of Abano attempted to reconcile the views of the Arabists and the Grecians, and the school of Padua was established as a center of medical dialetics. The school of Montpellier attracted the most prominent of the Arabists such as the alchemist, Raymond Lully, and Arnold of Villanova.

The regulation and restriction of medical practice began soon after the Christian era, but in spite of code of state and edict of church, not much was accomplished in elevating the status of the healing art, until the foundation of the great mediaeval universites, and the subsequent formation of "Guilds", by the physicians themselves. Under the legal restrictions of mediaeval times, the surgeon worked in jeopardy of his life and limb.

As the physicians looked down on the surgeons, so the surgeons of higher education, who in the middle ages could be counted on the fingers, looked down upon the barbers. The barbers were originally trained for the purpose of bleeding and shaving the monks. In this way barber surgery, the surgery of the common people, became wound surgery, that is restricted to blood letting and the healing of wounds. The lowest in the scale were the strolling montebanks who, in couching a cataract would sometimes put out an eye, who mangled the viscera in "cutting" for stone and in attempting to effect a "radical cure" for hernia, not infrequently excised "the radix of humanity itself."

Throughout the middle ages, there were some vague attempts to formulate the principles of medical jurisprudence. These are found in tribal laws, the Capitularies of Charlemagne, the Assizes of the Crusaders, the law of the Emperor Frederick, the Decretals of the Popes and general canon laws. The procedure was often of the crudest kind, the tests being by ordeal, torture, de facto verification of impotence, and "cruentation", or spontaneous bleeding of a corpse in the presence of the true murderer.

Medical ethics and medical etiquette were regulated in detail by stereotyped rules, even as to the bedside manner. The physician should not ogle the patient's wife, daughter or maidservant. If the convalescent show signs of ingratitude in the manner of payment, he might be temporarily sickened by some harmless dosing.

The chief glory of mediaeval medicine was the organization of hospitals and sick nursing. Several religious orders sprang up at the time of the Crusades,—the Alexians, the Antonines, the Beguins, the Hospitallers, the Sisters of St. Catherine, the order of St. John of Jerusalem, and the Teutonic Order.

Parallel with the specialization of the nursing orders during the Crusades, went the great mediaeval hospital movement initiated by Pope Innocent III, which has received the just encomium of

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Virchow. This Pope established the first Holy Ghost Hospital in Rome in 1198, and his example was soon followed all over Europe, so that nearly every city had its Holy Ghost Hospital. It became the ambition of every prince or landgrave to found a *Xenodochium pauperum debilium et infirmorum* —a hospital for poor and infirm pilgrims.

These institutions eventually became specialized as Noscomia, or claustral hospitals for the reception and care of the sick alone; Brephotrophia, for foundlings; Orphanotrophia, for orphans; Ptochia, for the helpless poor; Gerontochia, for the aged; and Xenodochia, for poor and infirm pilgrims.

When the mediaeval priest established in each great city of France a Hôtel Dieu, a place for God's hospitality, it was in the interest of charity as he understood it, including both the helping of the sick poor and affording to those who were neither sick nor poor an opportunity and a stimulus to help their fellowmen. About the beginning of the thirteenth century the hospitals began to pass from the hands of the ecclesiastical authorities into those of the municipality.

The city hospital movement was vastly aided by the immense spread of leprosy in the middle ages. Its spread in connection with the Crusades was appalling. The establishment of leper hospitals for the purpose of segregation was a potent factor in stamping out the disease.

During the Middle Ages, Europe was swept by epidemics as never before nor since. These were attributed to various supernatural or physical causes, but were of course due to the crowded condition and bad sanitation of mediaeval towns and the immorality occasioned by many wars. Wandering soldiers, students and vagabonds were factors in the transmission of disease. It was customary to regard eight diseases as contagious as listed in the following couplet from Rhazes:

Febris acuta, ptisis, pedicon, scabies, sacer ignis, antrax, lippa, lepra nobis contagia praestant.

As translated these diseases are:

Bubonic plague, phthisis, epilepsy, scabies, erysipelas, anthrax, trachoma, leprosy.

Scabies and lepra were often syphilis. Scurvey, influenza, epidemic chorea, sweating sickness and plica Polonica visited Europe as pandemics. Black Death and syphilis were later and more malignant visitations.

The mediaeval physician's case book, the Consilia, which were similar to our present day hospital record, were not introduced until the fourteenth century, although leading medical men had always kept some form of case record.

The great struggles for commercial supremacy and sea power in the middle ages were connected with the drug trade. The lucrative transport service required by the Crusaders in the Mediterranean brought about the rise of the Naval power of the Venatian republic. The influences of Arabic pharmacy, the actual contact of the Crusaders with their Moslem foes greatly enhanced the value of far Eastern drugs.

What was the appearance and manner of the Mediaeval physician? How did he dress and how conduct himself in public and in classroom? Some sidelight is afforded by the miniature paintings which illuminate many manuscripts, and the mosaics, engravings and frescoes in cathedrals and museums. The most famous artists, such as Giotto, Vanni, Rubens, Cimabue, Ghirlandajo, Holbein and others have depicted him vividly and accurately. Often he is shown inspecting the urine, a common practise of this age. The urinal became the emblem of practice, and was even used as a signboard device.

The clothes of the mediaeval physician were usually of a clerical cut, consisting of gown, cloak, cap, long woolen stockings and slippers.

The miniature paintings illustrate the physician carrying out the details of uroscopy, venesection, rectal irrigation, preparation of drugs, bedside scenes, with clinical and anatomic demonstrations, showing that the living nude body was sometimes boldly used for didactic purposes in anatomic and obstetric teaching.

Pathological conditions were often portrayed in painting and sculpture. Examples of these are a representation of rhinophyma by Ghirlandajo in the Louvre and a carved figure of acromegaly on a flying buttress of Rheims cathedral.

And so, in the nearly two centuries covering the period of the Crusades, we have seen medicine develop from a cult of faith healing and quackery into a budding science built upon solid foundations. These foundations included a reverence for the experience of the ancients as revealed in their written works, the beginnings of experimental research, university teaching and hospital practice, and the development of the auxiliary professions of nursing and pharmacy. The present day result of this evolution is that splendid and vigorous plant which we know as modern medicine.

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WATER POLLUTION CONTROL*

ARTHUR D. WESTON

The Author. *Mr. Arthur D. Weston, Chief Sanitary Engineer, and Director, Division of Sanitary Engineering, Massachusetts Department of Public Health, Boston, Mass.*

IN accepting the invitation of your President to address you on the subject matter of water pollution and water pollution control, I did so with considerable enthusiasm because the support of the medical profession is most essential in any water pollution program.

I feel that you are justified in asking the question, "Why all the interest manifest throughout the country on water pollution control at the present time?" My answer would be that the public, having become increasingly pollution minded, has begun to realize the need of additional authorization for most law enforcement agencies having to do with water pollution control. They demanded a change for the better. As Al Smith, the very beloved late Governor of New York State, would say, "Let's look at the record."

In the edition of the *Boston Traveler* of September 25, 1946, Mr. Harold L. Ickes had this to say in his column, "I'm Telling You":

"The pollution of our rivers, streams and beaches is an ever-growing menace. It is a threat to our recreation, our health and our food and water supply, and, like some other vices, it is extremely expensive. More than 3400 cities and towns inhabited by 29,000,000 persons discharge into our waterways a volume of 2½ billion gallons of raw sewage plus 3¾ billion gallons of industrial waste each day.

As a result, rivers that normally would provide ideal areas for play and sport have degenerated into stinking, disease-bearing cesspools of sewage and refuse. Fish cannot survive in them, swimming is suicidal, and from the esthetic standpoint they are decidely unpretty. There is also the expense involved in treating them to produce drinking and usable water. The annual economic loss resulting from water pollution has been variously estimated at from a hundred million to a billion dollars." . . .

Kenneth Markwell, when Assistant Commissioner of the Bureau of Reclamation, once stated:

"Recklessly we mined the soil of our farms and allowed it to waste into our natural waterways. Ruthlessly we cut away the forests that conserved moisture. Lush grasslands which provided our supply of cheap beef were overgrazed. Floods devastated millions of acres, and streams were polluted."

Relative to coastal pollution, the New York State Department of Health in its "Public Health News," Volume 12, No. 3, pages 402 and 403 had this to state:

"The use of the (sewage) receiving waters should receive first consideration because of ts direct bearing upon the health of its users. Certainly it is an undisputed fact that disease can be transmitted by polluted waters. The literature is voluminous with reference to epidemics of typhoid caused by the pollution of natural waters with sewage, and the matter has been so thoroughly investigated and demonstrated that there is no longer any doubt in the minds of the sanitarians concerning the causation of this disease. From our examination of other records, it also was noted that there is a well-formed opinion among sanitarians and medical experts that diseases other than typhoid may be contracted by coming in contact with polluted waters. These diseases, in general, are not of the type that are as important to the individual as typhoid, inasmuch as the person's life may not be endangered by them. The group as a whole, however, is an important item in injuring the health of the persons infected and causing a consequent loss due to lost time and medical treatment. We believe that in the aggregate this loss at the present time may be a greater one, financially, than that of typhoid fever, although its significance has long remained hidden.

Among those infections which, with the opening of the artificial bathing places, are becoming more severe, may be mentioned conjunctivitis, infections of the nasal passages, . . . sore throat, diphtheria, dysentery and ringworm. Information wth reference to these epidemics, in general, is suppressed, due to the fact that they often

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* Presented at the meeting of the Providence Medical Association, at Providence, March 3, 1947.

occur in sections which are devoted to recreation. It is for this reason, together with the fact that most of these diseases are not reportable, that the literature of this country is not more complete, as remedies have been sought and installed in order to prevent any possible condemnation of the questionable waters."

and as recently as 1943, the State Board of Public Health of California found it necessary to post the Santa Monica Bay beaches with signs which read as follows:

"WARNING
Beach Quarantine

This beach from high tide line seaward, including adjacent shore waters, is polluted with sewage and is dangerous to health. The public is excluded from these areas under order of the California State Board of Public Health.

The area under quarantine extends approximately ten miles along the coast from Brooks Avenue north of the Venice Pier in Los Angeles, to Fourteenth Street, north of the Hermosa Beach pier in Hermosa Beach.

VIOLATION OF THIS ORDER IS A MISDEMEANOR"

The Izaak Walton League of America, through their national office in Chicago, in reference to their national water policy referred to water as the "orphan." Quoting from their recent publication:

". . . There is nowhere in our Federal Government any coordinated national water policy. Amongst the various agencies having jurisdiction or control over water, not one is charged by statute, or by settled policy under that statute, to give first consideration to the public values inherent in natural waters or to give them any protection . . .

Prevent new and eradicate existing pollution to safeguard health and aquatic life."

The speaker could quote numerous resolutions adopted by technical societies throughout the United States—all aimed towards arriving at a solution of the many problems relating to stream pollution. It would take a very considerable time to cite the activities of these societies in this regard, and it would take a great deal of additional time to cite the work under way at the present time in various river valleys throughout the country, more especially under compacts or agreements between states such as the Ohio River Interstate Stream Conservation agreement, the Great Lakes Drainage Basin Sanitation agreement, the upper Mississippi River agreement, the work of the Interstate Commission on the Potomac River Basin, the work of the Interstate Sanitation Commission of Connecticut, New Jersey and New York, the work under the Tri-State compact between Minnesota, North Dakota and South Dakota and that of the Interstate Commission on the Delaware River Basin (Incodel) which includes Pennsylvania, Delaware, New Jersey and New York, but I assume that you are primarily interested in conditions here in New England.

In regard to our New England situation, I quote the following from the preface to a paper recently written by Richard Martin, Director of the State Water Commission of Connecticut:

"There are two potent reasons why Connecticut and New England industries or municipalities can no longer afford to knowingly pollute streams or other bodies of water if there is any reasonable or equitable method of avoiding it. The first is that any company which continues to 'pollute a stream or harbor is advertising an apparent lack of concern for public good will at a time when progressive industrialists are making every effort to achieve good relations with the public and their employees.' A second reason is that the federal government will soon take a hand in the abatement of stream pollution, in a manner far more costly and impracticable than now afforded, unless industry and municipalities quickly respond to the appeals for pollution control now being made by the State Water Commission of this and other states." . . .

The sanitary engineers of New England have been very active over a period of several years to provide a solution of our joint problems of water pollution. Collective action is necessary as action by any individual state against an industry has a tendency to encourage the industry to move into another state where laws in regard to water pollution control might not be so severe. As a result of conferences, these state sanitary engineers have agreed upon a classification of streams which I shall shortly describe. A report was made by these engineers to their respective Health Commissioners, and these Health Commissioners have agreed to the proposed classification, a form of compact has been agreed upon and already the State of Massachusetts has introduced this compact to the Massachusetts Legislature of 1947. Similar legislation is being introduced to the Legislatures of Maine and Connecticut.

A meeting called by the Massachusetts State Planning Board was held on February 17, 1947. All of the Health Commissioners of the Departments of Health and all State Water Commissioners in New England and others having powers of interstate negotiation were invited to attend this meeting. They agreed upon a compact form which provides in part as follows:

"Under Article I, the signatory states would agree that the compact would apply to lakes, ponds and streams which are contiguous to two

or more signatory states or would apply to interstate waters of two or more states whether inland or tidal. Under Article II, a commission known as the 'New England Interstate Water Pollution Control Commission' would be created. Under Article III, this commission would consist of five commissioners from each State. Article IV provides for an election of the Chairman of the commission, the employment of personnel, provisions for the conduct of meetings, the handling of funds, etc. Article V contains a recognition of the fact that 'no single standard of sewage and waste treatment and no single standard of quality of receiving waters is practical and that the degree of treatment of sewage and industrial wastes should take into account the classification of the receiving waters according to present and proposed highest use, such as for drinking water supply, industrial and agricultural uses, bathing and other recreational purposes, maintenance and propagation of fish life, shellfish culture, navigation and disposal of wastes.' This article authorizes the commission to establish reasonable physical, chemical and bacteriological standards of water quality and for the classification of its interstate waters. Under Article VI, the signatory states pledge to provide for the abatement of existing pollution and for the control of future pollution of such interstate inland and tidal waters."

It can readily be seen because of the varied uses of our water courses and tidal waters that an agreed use classification of waters is necessary in the execution of any compact. The classification agreed upon by the Sanitary Engineers of New England is similar to that of a sub-committee accepted by the National Resources Planning Board prior to the recent World War and is in accordance with the present and proposed highest use of waters as follows:

Class A—Waters used as sources of drinking water or for the cultivation of market shellfish.

Class B—Waters used for bathing.

Class C—Waters used for recreational boating, fishing, culture of seed oysters or industrial supply after treatment.

Class D—Waters used primarily for commercial navigation or transportation of wastes without nuisance.

A classification of nearly all New England streams has been agreed upon by these sanitary engineers in accordance with this plan.

Under these various classifications, the physical appearance, dissolved oxygen and bacterial quality of the water might be as follows:

Physical Appearance	*Dissolved Oxygen*	*Bacterial Quality*
Class A—Clear	Near saturation	*Better than 50 coliform organisms per 100 ml.
Class B—Clear	Near saturation	*Better than 1000 coliform organisms per 100 ml.
Class C—Free from slick, odors, or visible floating solids	***Adequate for fish life	No set standard
Class D—Free from slick, odors, or visible floating solids	Dissolved oxygen present at all times	No set standard

Some general observations as to the use of these classifications as suggested by the Special Subcommittee of the New England Regional Planning Committee are as follows:

"1. *Ocean harbors near large sewer outlets.* Such waters would appear to fall for the most part in Class D or less.

2. *Sea water not far removed from large sewer outlets but so situated that one tide does not carry sewage effluent to the area.* These waters would appear ordinarily to fall in Class C.

3. *Sea water along sparsely populated shore areas relatively free from pollution, or sea water outside of harbors.* These waters would ordinarily fall in Class A.

4. *Large rivers draining watersheds of large cities.* These waters would appear ordinarily to fall in Class C, although sometimes in Class D.

5. *Inland streams and lakes draining sparsely populated areas.* These waters should fall in Class A or Class B.

6. *Inland streams now receiving considerable volumes of sewage but not main carriers of wastes.* These waters may fall in Class C but by suitable treatment they may often be advanced to Class B."

What is Pollution?

In order to comprehend the need of compacts, the need of collective action by the various states in water pollution control and the need of water pollution control in each state, one should have a reasonable knowledge concerning the problems of water pollution. Some of these problems are rather complex and may not be as familiar to you as to the sanitary engineers engaged in such practice. For this reason, I take the liberty to illustrate the problem to you.

First of all, it should be understood that all streams and tidal waters receive a certain amount of pollution normal in characteristics to the virgin conditions of such waters. Such pollution results from the decay of organic matter normal to the waters or areas tributary to them. Also, under

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natural conditions, such waters have generally been able to care for such pollution by so-called natural or self-purification methods. However, characteristic to large concentrations of population, it has been necessary to establish water carriage systems known as sewerage systems to dispose of the waste of human life, waste from industry and other liquid wastes. This condition has introduced a problem of disposal without resulting in a nuisance, and the problem is greater in the inland cities and towns than in the coastal areas. It is still further aggravated in the older municipalities because of the use of common sewers for both storm water and sewage. As time has gone on, greater and greater uses have been made of local waters for final disposal of these wastes. The result has been that a greater and greater quantity of organic matter, putrescible in nature and containing bacteria and viruses, has of necessity been discharged into water courses as such courses were the only available outlet for the ultimate disposal of such sewage and waste. In connection with such discharges, more especially because of the presence of bacteria especially in the sewage from cities and towns having contagious disease hospitals and large numbers of persons, we have the danger of using the receiving waters for bathing and the taking of shellfish as well as the possibility of transmission of disease by flies which, as you know, thrive and multiply in polluted, damp, wet, soggy places. Where the water course may be used for public water supply purposes, the danger is very acute as the pollution load may exceed that under which a water purification plant may safely operate. In addition to bacterial and virus pollution, conditions arise in such waters whereby the necessary oxygen for self-purification may not be maintained with the result that anaerobic decomposition sets in or putrefaction of the organic matter takes place in the absence of free oxygen resulting in the generation of objectionable gases and nuisances in the vicinity. Such nuisances are deemed dangerous to the public health inasmuch as it is obvious that persons residing in and near such areas must eventually have reduced vitality due to loss of sleep, nervous conditions, etc. A certain amount of such objectionable conditions can be tolerated by the public but after a while there is a demand for correction.

In addition, you have the effect of organic matter and toxic influences from industrial wastes on fish and aquatic life which arouses the animosity of sportsmen and others interested in preserving aquatic life, and we receive complaints as to the effect of pollution upon various forms of recreation. Suits may result where the quality of the water used for industrial purposes is sufficiently damaged.

As you undoubtedly know, Rhode Island, New Jersey and Massachusetts, in that order according to the most recent Federal census, are the most densely populated states in the Union; Rhode Island having a density of population per square mile of about 670; New Jersey, 550; and Massachusetts, 540. In the case of the state of Connecticut, both the Department of Health and the State Water Commission have mandatory powers in the matter of water pollution control. In the state of Maine, there was established during this past year a Water Commission with considerable mandatory powers, but in New Hampshire and Vermont such powers are very limited. In the state of Rhode Island—

"The Rhode Island Department of Health is authorized and directed to regulate or prohibit the pollution of the waters of the state. Pollution is held to mean the entrance or discharge of sewage into any of the waters of the state in such quantity as to cause or be likely to cause either by itself or in connection with other sewage so discharged, damage to the public, or to any person having a right to use said waters for boating, fishing or other purposes, or owning property in, under or bordering upon the same. If any person is found to be polluting the waters of the state, the department may enter an order directing such person to adopt some practicable and reasonably available system or means to prevent pollution having due regard for the rights and interests of all persons concerned. If any person is guilty of pollution in violation of an order of the department, he may be punished by a fine of not more than $500.00 or by imprisonment for not more than one year or by both, and each month or part thereof during which such pollution in violation of the order takes place should be considered a separate and distinct offense. The Superior Court shall have jurisdiction in equity to enforce the orders of the department."

In the state of Vermont, an effort is being made through a publicity campaign by the Vermont State Chamber of Commerce to control pollution by educational methods.

It is to be expected that stream pollution problems will be perhaps more intense in the more densely populated states so far as the state as a whole is concerned. This has certainly been true in the case of Massachusetts where objectionable conditions in some of our water courses were recognized by the Massachusetts Legislature as early as 1884. Under an act of the Legislature of that year, a special commission was appointed to investigate and report as to the sanitary conditions of certain rivers in the eastern part of the State. That Commission, known as the Massachusetts Drainage Commission, reported in the year 1886. It recog-

nized the need of certain improvements, suggested a law which was later enacted permitting our then State Board of Health to establish a large experiment station, since known as the Lawrence Experiment Station, and laid the ground work for the Sanitary Engineering Division of the Massachusetts Department of Public Health. It provided that that Department should carry on experiments in the matter of treatment of sewage and industrial waste, that the Department should warn the persistent violator of all reasonable regulation and management of such wastes. However, the Commission was loath to clothe the Department with mandatory powers. In fact, they stated:

"It shall be their especial function to guard the public interest and the public health in relation with water, whether pure or defiled, with the ultimate hope which must never be abandoned that sooner or later ways may be found to redeem and preserve all the waters of the State. We propose to clothe the Board with no other power than the power to examine, advise and report except in cases of violation of the statutes. Such cases persisted in after notice are to be referred to the Attorney General for action. Other than this, its decisions must look for their sanction to their own intrinsic sense and soundness. Its last protest against willful and obstinate defilement will be to the General Court . . ."

Experience since that time showed the necessity of appealing to the General Court for additional powers. For example, in connection with, or as a result of, the pollution of the Neponset River, special legislation was enacted in 1902 giving the Department mandatory powers in relation to that stream. Similar legislation was enacted in 1907 regarding the pollution of a stream in the easterly part of the State known as Horn Pond Brook, and legislation was enacted in 1911 regarding the Aberjona River; in 1914, the Assabet River; and in 1918, Alewife Brook. Later legislation regarding the Charles River was enacted; while in 1929, legislation was enacted for the protection of certain coastal waters. It was not until 1945 that the Legislature provided all inclusive legislation in regard to lakes, ponds, streams, tidal waters and flats and tributaries thereto. Under this latter legislation, the Department was authorized to prescribe rules and regulations. Such rules and regulations have been prescribed by the Massachusetts Department of Public Health, and it has been necessary only in few instances for the Department to take cases of violations into the courts. In many cases violations have been brought to the attention of the municipality or industries involved and have been settled satisfactorily outside of the courts.

To illustrate how this problem is far reaching throughout the country, I might state that there was presented to the 79th Congress, 2nd Session, a number of bills providing for national water pollution control, and there are before the present Congress at least four bills; viz., H.R. 123, H.R. 315, H.R. 470 and S. 418; also a bill, S. 244, to encourage the prevention of stream pollution by allowing amounts paid for plants for the treatment of industrial waste as a deduction in computing net income. It is interesting to note that since 1897 about one hundred bills have been introduced in Congress in this regard but all failed to pass. Most of us believe that the main reason for this failure is because of the fear of providing an extension of Federal control. It appears only natural that there would be such fear as since the inception of the United States Government, there has been a definite feeling against the releasing of State rights.

It is because of these accumulated aggravating conditions that throughout the country as a whole there has been a deluge of requests for either State or Federal legislation for water pollution control. I believe that the problem should be attacked in a sane and intelligent manner under a program which will adequately protect the public health on the one hand and not make it impossible for industry to survive. I believe that the problem can be solved without Federal interference. Remedial programs must be such as can be properly financed. In New England this problem is being attacked in a sane and intelligent manner by the State Departments of Public Health and the State Water Commissions.

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WATER POLLUTION LEGISLATION

Most of the public, we presume, were pleased to read in large headlines of the press recently that an anti water pollution bill had become law. Accompanying the news a handsome tableau was presented showing the signing of the bill. Caspar Milquetoast, M.D., was not a figure in the tableau and yet there is little doubt that without his modest but determined efforts the event would have been indefinitely postponed.

The committee from the State Planning Board did a lot of hard work on this project but it was stopped by the war and in the words of that greatest of Democrats, Grover Cleveland, it was in a state of "innocuous desuetude." Then the Providence Medical Association, by its President, Dr. Paul Cook, appointed a committee a year ago. This committee was able in short order to get a fairly accurate idea of the problem from a study of the State Planning Board's work. The resulting report was frank and aroused some adverse criticism, but it certainly put plasma into the veins of a mighty decrepit patient.

The conclusions which were most vigorously assailed have since been most emphatically vindicated by official action. This JOURNAL backed up the committee of the Medical Association whole heartedly; Dr. Cook devoted his Presidential Address to water pollution, the State Society took over the problem from the local association, and at the March meeting of the latter organization, Dr. Charles A. Stuart, Professor of Biology at Brown University and Mr. Arthur D. Weston, Chief Engineer, Massachusetts Department of Public Health, gave highly important talks.

And now everybody in our community seems to be as much "agin" pollution as Cal Coolidge's preacher was "agin" sin. The plans of the State Board of Health were necessarily interrupted by the war but now under the supervision of Mr. Walter J. Shea, Acting Chief of the Division of Sanitary Engineering of the Rhode Island Department of Health, they are actively pressing the campaign. No better first move towards reform could be made than impounding and treating the liquid feces of Pawtucket and other Blackstone Valley communities.

But if the referendum is accepted and the Blackstone Valley plant built, only one particular source of pollution has been solved. There remain the nasty Moshassuck, and Woonasquatucket, the inadequate sewage systems of Providence and other communities, the Navy's sewage—in the past an enormous offender. Manufacturing plants may still be dumping enough chemicals to kill the fish and oil may still be killing ducks, smearing the shores, and killing oyster spawns.

Among the five anti-pollution bills just passed by the legislature, one aims to help control the oil problems. Due to aroused public opinion, efforts in the various communities to improve their sewage systems are underway. A commission has been appointed to handle the Blackstone Valley project but machinery is needed for all the other jobs.

The public must not be allowed to sink back into its somnolence, even to the point of lethargy, which has for years prevailed. It is going to require a long, patient and intelligent effort to keep the necessary work going for the regeneration of our Bay.

BRISTOL COUNTY ORGANIZES

The Rhode Island Medical Society is the only state medical organization that does not have all its constituent member groups as county societies. For geographical reasons our state medical society has chartered three county societies and three district societies until this year. Now, by action of the House of Delegates, a charter has been issued to the physicians of Bristol County to permit them to form a constituent association in that area. Thus the Bristol delegation moves from the jurisdiction of the Providence Medical Association.

In spite of the limited number of physicians in the county the new organization should prove a valuable asset as an independent association. Enthusiasm for local projects, and study of local problems, can best be carried forward at the local level. The Bristol county physicians are in a position to contribute much to the community and professional planning in their area, and they may well emulate in time to come the example of the Kent County society which has initiated action for its general hospital.

They can render additional service to the State society by active participation in the work of the Council, the House of Delegates, and the various committees. We wish Doctor Merchant, first president of the new Association, and his colleagues, success in the development of the newest unit of one of the nation's oldest state medical societies.

PROVIDENCE URBANITY, 1836-1947

Dr. Reginald Fitz of the Harvard Medical School, recently President of the Massachusetts Medical Society, and one of the prominent figures among the country's internists, is historically minded as evidenced by many articles he has contributed to our literature. Being this way he must realize the propriety of our mentioning that he is the son of Reginald Heber Fitz who first recognized and described acute appendicitis and acute pancreatitis. Recently he came to Providence and gave a charming talk about Dr. Oliver Wendell Holmes. Now he sends us the following letter and the accompanying aspects of life here over a century ago:

"To the Editor
Rhode Island Medical Journal.

"I have just experienced the pleasant hospitality of Rhode Island at a meeting of the Friends of the Library of Brown University. I can best express my gratitude to my hosts through the words of a distinguished fellow Bostonian; for I believe that the people of Providence have lost nothing in charm or in urbanity during the changing times of the last hundred years.

Yours sincerely,
(Signed) Reginald Fitz, M.D."

* * * *

"(From the diary of Benjamin Waterhouse, M.D., late Professor of the Theory and Practice of Physic in the University of Cambridge and of Natural History in the College of Rhode Island.)

"November, 1836. Having accepted a written invitation of the Rhode Island Historical Society to deliver a Public Discourse before them on some subject connected with the views of that association, and some time before the middle of November, and having received a second request that I would give the Introductory Lecture during the sitting of their Legislature, I went to Providence the 4th of November in my own carriage, driven by Ed. Battles, and arrived there the 5th. I avoided the rapid steam carrs, as too *whirligigiglish* for a man who wished for a cool and steady head. The day contemplated and advertised the 3d, was ushered in by snow and rain which abating towards night gave something like fair weather on the 6th when I gave my Discourse in Franklin hall to a very respectable audience of both sexes; and to universal satisfaction as a patient audience testified during one hour and twenty-five minutes.

"I chose for my subject, *the Duties and Qualifications of a Consummate Historian.* . . . I endeavored not to diminish the solemnity of my subject, nor my serious manner of enforcing it; and I found that all who conversed with me subsequently seemed to treat me as a minister rather than a physician.

"They had provided for me in a very pleasant family—that of the Reverend Romeo Elton—a Professor of Greek and Latin, and Antiquities, and Secretary of the Historical Society. He and his amiable wife seemed to exert themselves to make every thing agreeable to me, in which they succeeded. Having no children, their house was tranquil, their accommodations excellent and their company collected out of respect to me, of the most excellent of both sexes. After tarrying with them nearly a week, I returned home in one day, in good health and highly gratified. . . .

"September 7th. Went to Providence Commencement. Very good speaking, and the English compositions of rather higher grade than here in Cambridge. A vast collection of people, quiet and orderly, everything on the whole exceeding the oldest University in New England for a show of riches and splendor. The dress of the opulent female exceeded anything ever exhibited here. The number in the dinner-hall very large.

"As far as I am able to judge, the City of Providence exhibits more taste, opulence and refinement than any city can or does exhibit in Massachusetts. . . . Their college and schools are in a fine condition and their streets clean and

continued on next page

commodious, and there is more of the economy and neatness in the busy part of the town than I have seen anywhere else. . . . On the whole, they appear to be a high spirited people capable of anything they set their minds on. I may be mistaken, but I suspect the college feels something like jealousy of the Rh. Island Historical Society lest it should grow into another Royal Society, or Academy of Arts and Sciences—a seminary of Science for grown up men, who think and act for themselves, and not an overgrown school of youth who are trained to repeat handsomely the sentiments of men endowed with experience and matured knowledge. The volumes of the transactions of the Rhode Island Historical Society published from time to time will give such a permanent history of progressive science that will over-top occasional effusions of elocution and oratory.

"*September 8th.* I returned from Providence Commencement in the rail carrs for the first time in my life, and found them very convenient and not unpleasant, but not so rapid as I was made to believe. They ran about 20 miles an hour, and stopped a few minutes three times."

UNFAVORABLE PUBLICITY

Frequently, when Organized Medicine locally finds itself in a position where it must take a stand on a matter of general public interest, it may happen that the ultimate expression of its opinion is at variance wth the true convictions of a majority of its members because public airing of those convictions might lead to "unfavorable publicity." Time and again, the bugaboo of "unfavorable publicity," has arisen to color the decisions of our Comitia Minora, Stated Meetings and Coordinating Council. This has been the case, in the main, where a large organization, such as Associated Hospital Service, Health Insurance Plan, or the Red Cross, or a powerful individual, such as the recent Mayor, has been involved in the matter at issue. To invite opposition of this calibre by differing with their views is frequently tantamount to calling down upon ourselves the full wrath of well-organized publicity bureaus. Rather than risk this, we have acquired the tendency to modify our pronouncements so as to make them acceptable, and by this means avoid unpleasantness, regardless of whether we have revealed our true feelings.

The proponents of such obfuscation rationalize by talking of the "spirit of compromise." Harsher critics lean more toward "appeasement," with all the connotations that have come to be associated with the word. And they may properly question if honest expression can prevail, where a threat to our well-being is the penalty for non-conformity. By what stretch of the imagination can the true sprit of compromise maintain beneath the sword of Damocles?

—From an editorial in the Bulletin of the Medical Society of the County of Queens (NY).

(The JOURNAL regrets that part of the poem below was inadvertently omitted in the reprinting of it in the March issue. The poem in its entirety, and as originally published, is now reprinted correctly.

. . . The Editors)

"THE SONG OF A MAN'S OWN HEART"

Systole-diastole the whole day through
In a never-ending sequence while you live by what I do
With your life blood passing through me in a cadence like a song
Systole-diastole the whole day long.

S y s t o l e - d i a s t o l e the long night hours
While you rest I still am working though I'm garnering my powers
For the efforts of the morrow for the travail and the fight
S y s t o l e - d i a s t o l e through all the night.

Systole! Diastole! is it fear or is it rage!
Or perchance it's joy that keeps me knocking 'gainst my bony cage
You can sense my throbbing tumult or as keen as joy or fear
Systole! Diastole! when your mate is near.

SYSTOLE! DIASTOLE! you are prostrate on your bed.
And the poisoned torrent rushes, clouding brain and aching head,
I, your ally in extremis, fighting foetid fever's powers
SYSTOLE! DIASTOLE! oh the long hours!

Systole-diastole now the race is almost run
Long the years we've toiled together in the shadow and the sun
May the germ cells of our offspring carry what of us is best
Systole-diastole systole-diastole
s y s t o l e - d i a s t o l e REST!

—Alex M. Burgess, M.D.

(Reprinted from the Rhode Island Medical Journal, May, 1927)

PATRONIZE

JOURNAL

ADVERTISERS

PROGRAM . . . 136th ANNUAL MEETING

RHODE ISLAND MEDICAL SOCIETY

May 14-15, 1947 *At the Rhode Island Medical Society Library, Providence*

WEDNESDAY, MAY 14

2:00 P.M. CALL TO ORDER
WELCOME BY PRESIDENT, Herman C. Pitts, M.D.
RECOGNITION OF DELEGATES FROM OTHER SOCIETIES

Presiding: JOHN F. KENNEY, M.D., *Immediate Past President*

2:15 P.M. "PSYCHIATRIC LESSONS LEARNED IN THE army"

MALCOLM J. FARRELL, M.D., of Waverley, Massachusetts

(Superintendent of the Walter E. Fernald State School; Chief Consultant to the Surgeon General, U. S. Army and the Cushing Veterans Hospital; Instructor in Psychiatry at Boston University Medical School and Tufts College Medical School.)

2:45 P.M. "ANTI-BIOTIC AGENTS IN CLINICAL MEDICINE"

CHESTER KEEFER, M.D., of Boston, Massachusetts

(Physician in Chief, Massachusetts Memorial Hospitals; Professor of Medicine, Boston University School of Medicine.)

3:15 P.M. "USE OF ESTROGENS AND PROGESTERONE"

ELMER L. SEVRINGHAUS, M.D., of Nutley, New Jersey

(Director of Clinical Research, Hoffmann-LaRoche, Inc., Consultant in Endocrinology and Nutrition.)

3:45 P.M. INTERMISSION TO VISIT TECHNICAL EXHIBITS

4:15 P.M. THE CHARLES V. CHAPIN ORATION

"Control of Typhus Fever"

STANHOPE BAYNE-JONES, M.D., of New Haven, Connecticut

(Professor of Bacteriology, Yale University School of Medicine; President, Army Epidemiological Board, Office of the Surgeon General, U. S. Army; Formerly Brigadier-General, MC, and Director, United States of America Typhus Commission.)

continued on next page

5:15 P.M. TOUR OF THE TECHNICAL EXHIBITS

6:00-7:00 P.M. RECEPTION . . . . . At the Narragansett Hotel
(For Members of the Society and their Guests)

7:00 P.M. DINNER . . . . . At the Narragansett Hotel
(*For Members of the Society and their Guests*)

9:00 P.M. *Presiding:* FRANK T. FULTON, M.D., of Providence
Anniversary Chairman

Presentation of the Charles V. Chapin Memorial Award:

HON. DENNIS J. ROBERTS
Mayor of the City of Providence

Greetings from HON. JOHN O. PASTORE, *Governor of Rhode Island*

President's Message: HERMAN C. PITTS, M.D.,
President, Rhode Island Medical Society

THURSDAY, MAY 15

At the R. I. Medical Society Library

Presiding: MICHAEL H. SCANLON, M.D., *Vice President*

11:00 A.M. "CURABLE HEART DISEASE"

MARSHALL N. FULTON, M.D., of Providence

(Physician, Department of Medicine, and Associate, Department of Cardiology, Rhode Island Hospital.)

11:30 A.M. "COMMON DERMATOLOGICAL CONDITIONS AND THEIR TREATMENT"

WILLIAM D. WOLFE, M.D., of Baltimore, Maryland

(Attending Dermatologist, South Baltimore General Hospital and Mercy Hospital; Instructor in Dermatology, Johns Hopkins University.)

12:00 NOON BUSINESS MEETING OF THE SOCIETY
INSTALLATION OF OFFICERS FOR 1947-48

12:30 P.M. LUNCHEON (A buffet lunch will be served to members of the Society in the basement dining room)

Presiding: ARTHUR H. RUGGLES, M.D., *President-Elect*

2:00 P.M. "LOBOTOMY"

HANNIBAL HAMLIN, M.D., of Providence

(Consulting Neuro-Surgeon, Butler Hospital, Emma Pendleton Bradley Home, Chelsea Naval Hospital, Boston State Hospital)

2:30 P.M. "TRENDS IN PART-TIME INDUSTRIAL HEALTH SERVICE"

CRIT PHARRIS, M.D. of Hartford, Conn.

(Assistant Medical Director, United Aircraft Corporation, East Hartford, Conn. Formerly Industrial Hygiene Physician, Connecticut State Department of Health, and formerly Director of Industrial Hygiene Service, Tennessee Department of Health.)

3:00 P.M. INTERMISSION TO VISIT TECHNICAL EXHIBITS

3:30 P.M. PRESIDENTIAL ADDRESS:
"CHANGES IN MEDICAL PRACTICE"

HERMAN C. PITTS, M.D., of Providence

(President, Rhode Island Medical Society; Former President of the American Society for the Control of Cancer.)

4:00 P.M. "IS ASTHMA A SYMPTOM OR A DISEASE?"

FRANCIS M. RACKEMANN, M.D., of Boston, Massachusetts

(Physician and Chief of Allergy Clinic, Massachusetts General Hospital; Lecturer in Medicine, Harvard Medical School.)

ALLIED MEETINGS

WEDNESDAY, MAY 14

At the R. I. Medical Society Library

THE RHODE ISLAND ASSOCIATION OF MEDICAL RECORD LIBRARIANS

Presiding: MISS MARY NUNEZ, R.R.L., *President*

10:00 A.M. BUSINESS MEETING

11:00 A.M. "RECORDS AND NEUROPSYCHIATRY"—LAURENCE A. SENSEMAN, M.D.
(*Chief, Neuropsychiatry Division, The Memorial Hospital, Pawtucket, Rhode Island*)

11:30 A.M. "THE LEGAL ASPECT OF MEDICAL RECORDS"—HON. PATRICK P. CURRAN
(*Judge of the Superior Court, Providence, Rhode Island*)

Exhibitors at the

136th ANNUAL MEETING OF THE RHODE ISLAND MEDICAL SOCIETY

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3	Blanding & Blanding
4	Ciba Pharmaceutical Products, Inc.
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10	The Coca-Cola Bottling Company of R. I.
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12	The Doho Chemical Corporation
13	Boss & Seiffert Company, Inc.
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25	U. S. Vitamin Corporation
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HEALTH MAINTENANCE CLINIC FOR CANCER PREVENTION AT THE PAWTUCKET MEMORIAL HOSPITAL

PURPOSE: To encourage so-called well people to have semi-annual examinations with particular reference to parts frequently affected by cancer and to discover conditions which are the forerunners of cancer.

From a research point of view, much of the value of these periodic health examinations will be the data accumulated over the years.

Those who come for an examination are called "examinees" rather than patients because no one who is ill or is under treatment is given an appointment. The clinics give no treatments. Their one function is examination with special emphasis on conditions which may lead to cancer. Another function is public education. It is hoped these examinees will, by their example, encourage their friends to do likewise and seek examinations at least twice a year from their physicians or a clinic with the particular reference to conditions which may lead to cancer.

ORGANIZATION: With funds from the State of Rhode Island, the clinic is furnished with nurses, laboratory technicians and other personnel pertinent to the functioning of these clinics. Two doctors and an alternate will conduct the examination and the clinic will be supervised by a director.

These clinics will be held once a week on Monday mornings. Examinees will be given appointments in advance and the number of examinees per morning will be limited to the capacity of the clinic.

After examination, if no conditions are found which are suspicious, an appointment will be made for six months later. Whenever there is a positive finding, the examinee is referred to her physician and the latter is requested to report back upon the treatment given. Should the condition be urgent, the examinee may be sent immediately for treatment but in the case of the least urgent ones, there will be a slight delay until laboratory data has been received. Records being based on reports from personal physicans are kept of what treatment is administered, when, where and by whom.

ROUTINE OF THE EXAMINATIONS: The examinations are complete physicals, including skin, mouth, tongue, pharynx, larynx, breast, pelvic, rectum, lymph nodes, feet, etc.

Routine laboratory test—blood, urinalysis and Wassermann. Cervical smears are taken and studied by the Papanicolau method. When special studies are indicated eg. cystoscopy, biopsy, G.I. series, etc., these are done wherever the examinee or his physician desires. Such special diagnostic procedures are not provided at the clinics.

It is felt that this is a step forward in the battle against cancer with the hopes that early detection may be obtained. It is not to be considered a tumor clinic because tumor clinics are already organized and the patients who suspect they have tumors are still referred to our tumor clinics. This group of people, we presume to be well people and only as such will be accepted. The importance of early detection of cancer cannot be overestimated. Almost without question, early cancer is curable. It is true that in many parts of the body, cancer does not give early symptoms but it is likewise true that in some of the most common parts of the body, cancer gives early symptoms. It is a notable fact that from the clinics already established around the country, there is an average af about 50% where the so-called well people were referred for treatment of some condition found at these clinics.

The staff consists of Dr. G. Raymond Fox, director, and Drs. Francis E. Hanley, Hrad Zolmian, and Dr. James Chapman, alternate.

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SEARLE

RESEARCH
IN THE SERVICE OF MEDICINE

CLINICOPATHOLOGICAL CONFERENCE

Memorial Hospital, Pawtucket, R. I.

Case No. 66675

A 46 year old American male was admitted complaining of:

Loss of weight, two months' duration.

Weakness, pain in epigastrium and tarry stools, six weeks' duration.

Patient states that he has always been well until two months ago when he noted loss of appetite and beginning loss of weight, twenty pounds during the past two months. Six weeks ago while at work as a yardman at the Anaconda Wire Works he had some sharp pain in the epigastrium and he felt dizzy and complained of thirst. Since that time he has had almost continual abdominal pain and states that his stools have been tarry and constipated. The day before admission, he vomited what he described as coffee ground material.

Physical examination revealed an emaciated, sallow appearing male of 46, complaining of pain in the epigastrium. A complete physical examination was made and the findings were within normal limits except for the abdomen which was described as being flat, no scars. There was a 6 cm. x 8 cm. firm mass in epigastrium. Pulsation and bruit most marked over region of mass. Some guarding and tenderness. Peristalsis present.

T. 100 P. 110 R. 20 Blood pressure 130/90.

During his stay in the hospital, condition remained essentially unchanged until the 9th day. The pain in the abdomen was more or less constant and he required morphia approximately twice a day. He got no relief from food or soda. Temperature ranged between 98 and 100. Pulse 70 to 120. Respirations 20 to 30.

On Admission:

Hemoglobin 38%; R.B.C. 2,490,000; W.B.C. 18,100; Polys 85%; Lymphs. 14%.

Blood urea nitrogen 13.8; sugar 96.

Icteric index 5. Occult blood from stool positive.

3rd Day:

The blood pressure was found to be 80/44 with no change in general condition. X-Ray—"Barium meal studies of the G.I. tract had to be carried out in the horizontal position because of the patient's poor condition. As far as could be determined the stomach and duodenal bulb showed no definite abnormality. However, the remaining portions of the duodenum, namely the second, third and fourth portions described what appeared to be a rather wide arc, with slight narrowing and spasticity of the second portion of the duodenum. This finding is suggestive of enlargement of the head and body of the pancreas, possibly neoplasm although a definite etiological diagnosis cannot be made from the x-ray examination alone. There was no obstruction."

4th Day:

1/19/44—Surgical Consultation:

"This man appears to have a hard mass the region of the epigastrium. The abdominal veins are enlarged, suggesting portal vein obstruction. This mass could come down from the liver; it might well be retroperitoneal as you have suggested from the pancreas. However, blood in the stool would not be explained. This does not feel grossly as though it were connected with the stomach.

Recommendations: Suggest x-ray of chest in particular; also, in standing position to get a relative idea of the diaphragm. His Wassermann report is not back yet. If there is nothing to contraindicate an exploratory, when these tests come back, would advise the same.

5th Day:

X-Ray—"Examination of the chest shows some dense bands radiating out from the left hilus which suggests the presence of an area of fibrosis possibly from an old tuberculous process. The findings were otherwise essentially negative. There was an anomaly of the right first rib which is underdeveloped and is fused at its anterior end to the slightly deformed second rib. Both leaves of the diaphragm showed no definite abnormality.

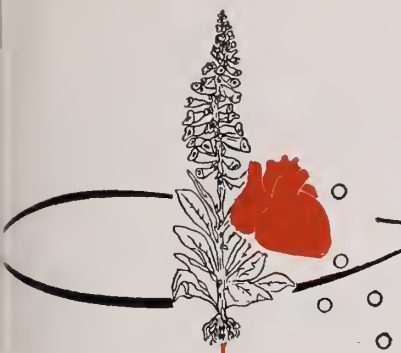
9th Day:

At 8:00 A. M. the patient was comfortable and took his diet well. T. 98.6—P. 108—R. 20. At 11:45 A. M. he complained of severe pain in right lower quadrant and "diarrhea" and he went into collapse. His pulse became weak and thready, respirations shallow and he died at 12:20.

DR. H. ZOLMIAN:

"This is the case of a 46 year old man with two months weight loss, six weeks of epigastric pain, tarry stools and weakness as chief complaints. He

continued on page 278



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CLINICOPATHOLOGICAL CONFERENCE

continued from page 276

had one coffee ground vomitus. On examination twice it is recorded that he had hard epigastric mass and x-ray showed question of deformity or spasm at the duodenal arch. He showed by laboratory tests hypochromic anemia that would be consistent with blood loss. He had dilated veins which might be significant indicating possible portal obstruction and a terminal episode which seemed to be massive hemorrhage which proved to be fatal. Dr. Benjamin is not able to attend to demonstrate the x-rays so I think we will take his reports as they stand without demonstrating them. To start with I think we could rule out a primary bleeding disorder since there is no evidence in history or laboratory work or other indications in record that he might have had it. Obstructive lesions I think can be ruled out as he had no signs of being obstructed. Abdomen flat and peristalsis heard.

Some conditions which may cause intestinal bleeding such as intussusception, volvulus and tumors of the small intestine usually cause some obstruction and we might rule them out.

The location of this bleeding I think would help us in localizing and diagnosing the case. Since he had tarry stools I do not believe he had bleeding from the colon or ileum. I do not think it would be described as tarry. Bleeding from the jejunum might give us tarry stools but I do not believe it would give us bloody vomitus which is described. There might have been obstruction with a jejunal lesion but as I said before there has not been any indication of obstruction with this mass. Pain and melena, if they persist with negative x-ray nevertheless make us consider a small intestinal condition as being a possible reason for the bleeding. That brings us to bleeding somewhere between the pharynx and the end of the duodenum at the ligament of Treitz. If we had bleeding in this region we should consider bleeding from the duodenum, stomach or lower end of the esophagus with varices as a cause for bleeding. With a mass described as the other chief sign, I think we should consider some condition such as pancreatic cyst or mesenteric cyst which might pulsate because of transmission from the aorta retroperitoneally. However, even though they might bleed I doubt that that would give us bleeding in the intestinal tract.

Retroperitoneal tumors such as lipoma and sarcoma might grow and show this mass but I do not believe that this is such a rare tumor especially in such a position with the bleeding described. Dilated gall bladder due to some neoplasm at the duct or in the gall bladder itself might give us a mass. However, I would think of other gastrointestinal symptoms in the history and probably some jaundice.

Infections—We might consider infections in this region with the formation of an abscess, for example, acute or chronic pancreatitis. An abscess might develop a mass in this region. However, fever and white count in this case are not enough to account for that type of infection. Infection of a milder nature I do not believe would give us this mass and I think the fever and white count in this case we can account for by the large amount of blood in the bowel.

Bleeding varices might give us a massive hemorrhage such as described. A rare condition such as Banti's Disease might but I do not believe that this man has such a condition because the spleen is not described to be enlarged. Cirrhosis, we would expect, would give us portal obstruction and bleeding but the liver has not been described as enlarged. Gastritis I am ruling out because there were no previous symptoms. I am trying to tie in this mass with the bleeding and I do not believe gastritis would give us such a mass. In these conditions we would expect some signs by x-ray and x-rays are negative for deformity. Hitaus hernia with gastritis may be ruled out for the same reasons.

Some benign tumors such as polyps of the stomach might give signs as in this case but are not demonstrated by x-ray. Leiomyosarcoma, fibroma and neuroma are tumors of the stomach which might give bleeding and might not be shown by x-ray. These are rare and I do not believe this man had any of these tumors. Ulcer or carcinoma of the stomach might not have been demonstrable by x-ray in this man but I still believe that some deformity should have been shown in the x-ray and I am ruling these out. Rarely you may have a pancreatic cyst that might ulcerate and bleed. However, these are rare and I do not believe this man has such a condition. Duodenal ulcer is the most common lesion which would give us fatal and such massive hemorrhage. But, I could not account for the mass and fit it in with the diagnosis.

I have selected a few conditions which could fit in with this history and examination which might give us massive hemorrhage and a mass in the epigastrium together. I have considered cirrhosis of the liver with a possible portal obstruction and with a left lobe palpable in the epigastrium. Since the right upper quadrant and that portion of the liver has not been mentioned, it is hard to fit this in especially without other symptoms, except dilated veins in the abdomen. In syphilitic livers, it is said that this left lobe might enlarge out of proportion to the rest of the liver. I understand that a Wassermann was not reported.

I am considering, also, the possibility of a primary liver tumor which again might give us a mass in the left lobe or a mass in the epigastrium, transmitting pulsation from the aorta posteriorly, either

continued on page 280

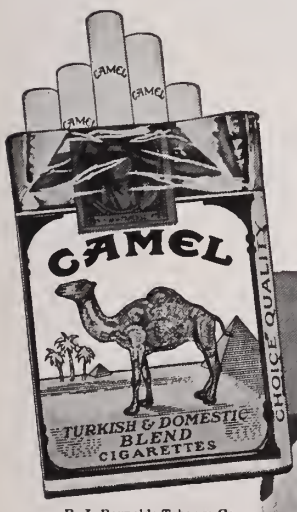
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The experience gained from hundreds of dissections was the basis for Henle's many discoveries—the tubules of the kidney, the muscular coat of the arteries, the epithelial coverings of the surfaces of the body, the minute anatomy of the eye and of various brain structures. Henle's brilliant work proved—*experience is the best teacher.*

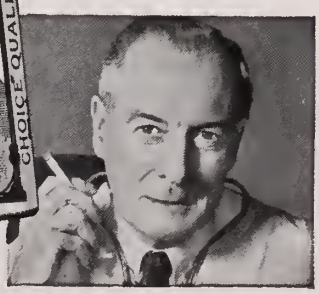
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R. J. Reynolds Tobacco Co.
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CLINICOPATHOLOGICAL CONFERENCE
continued from page 278

syphilitic cirrhosis or hepatoma might give us a venous hum in this region. Abdominal aneurysm is another condition to consider which might give a mass here with pulsation and murmur. However, it is hard to conceive of its eroding through the retro-peritoneum causing bleeding for six weeks and not ending fatally before this long period. Usually the abdominal aneurysm might erode and bleed retro-peritoneally or into the peritoneal cavity. Besides in aneurysm, we might expect some other changes such as changes in the blood pressure with a difference between arms and legs. In an aneurysm especially I would like to have an expansile type of pulsation described rather than just a pulsation, as a pulsation might be transmitted through overlying tumors from the abdominal aorta.

Leiomyomata of the stomach or duodenum might give us a tumor without signs or symptoms which might project away from the direction of the lumen and finally erode and cause bleeding. This might transmit pulsation and give us the tumor with bleeding and I think I consider that as one possible diagnosis. Slight x-ray change at the duodenum may indicate that there was a tumor here. Pancreatic carcinoma is another one that I might consider. This man did not show signs of jaundice. Although we would expect jaundice in two-thirds of the cases, this might fit the one-third without jaundice. Pain is described in three-quarters of the cases. It is possible that this man had a pancreatic tumor which might fit the pain and could transmit pulsation and erode into the duodenum to give us the bleeding which pancreatic carcinoma may occasionally give. It could as with cancer of the stomach or duedenum or gastrointestinal tract cause an invasive thrombophlebitis with portal obstruction and dilated veins.

I am considering that the terminal event was a massive hemorrhage with this feeling of "diarrhea", due to fatal hemorrhage and pain in the right lower quadrant as result of hemorrhage.

I am not going to restrict myself to one single diagnosis but offer the following:

(1) Carcinoma of the Pancreas
(2) Leiomyoma of the Duodenum
(3) Abdominal Aneurysm
(4) Cirrhosis or Tumor of the Liver"

DR. J. P. EDDY, 3RD:

"In listening to Dr. Zolmian, I was rather impressed with the fact that this patient has had no back pain, at least none was mentioned. Back pain is frequently associated with pancreatic carcinoma and also with intra-abdominal aneurysm. Because it was not mentioned, I rather thought he probably did not have that type of pain, therefor, I would not lean quite so strongly toward either of those diagnoses.

His symptoms suggest gastrointestinal bleeding. There is no mention here of a gastric analysis which would be helpful, but nevertheless, he vomited coffee ground material and had blood by stool and loss of weight, and because of these, one would have to seriously consider gastric carcinoma.

My feeling would be that he had a malignancy and died from malignancy and probably malignancy of the stomach or a malignancy which penetrated through to the gastrointestinal tract with hemorrhage."

DR. F. WEBSTER:

"First the blood pressure was 130/90. Three days later, the blood pressure was 80/40. I think that in consideration of this man's illness, we could have had more information particularly about the genito-urinary tract. Also a retroperitoneal sarcoma or neoplasm affecting adrenal glands and possibly overlying and compressing the aorta, thus causing constriction and giving a perfectly good mechanism for transmitting sound from the mass, could well explain the bruit."

DR. H. B. MOOR:

"This patient apparently was doing reasonably well except for abdominal pain up to the day of his death. Was reported comfortable at 9:00 A. M. There was a sudden change in his condition between 9:00 A. M. and 11:45 when he was given morphine. It is interesting to note as has already been suggested, no mention of back pain has been made. It is unusual to have a tumor in this area and particularly associated with the pancreas that would not give considerable back pain. In view of the fact that he had an abdominal tumor with a bruit, most marked over the region of the mass, I believe this patient died of hemorrhage following a rupture of an abdominal aneurysm. One would have to also consider a ruptured viscus. Possibly, a carcinoma of the stomach, perforated, with hemorrhage."

DR. E. J. MARA:

"I do not think that there has been too much said about the acute onset, loss of blood, and drop in blood pressure. There is a possibility of a hematoma forming in this area and accumulating blood. A bleeding duodenal ulcer with accumulation of blood and hematoma would be consistent in this case."

DR. B. E. CLARKE:

"The autopsy findings are recorded as follows: 'On opening the body cavity three very large clots of blood were found, one each in the right and left fossae and one in the right lower quadrant. The intestines were prominent with slight dilatation of

continued on page 284

Footprints on the sands of time

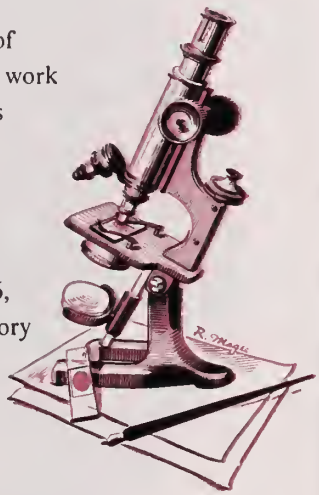
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COUNCIL ACCEPTANCE

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Pyribenzamine now has been formally accepted by the A.M.A. Council on Pharmacy and Chemistry. A report to the Council on anti-histaminic agents was written by S. M. Feinberg, M.D., in the November 23, 1946 issue of the J.A.M.A. Pyribenzamine was found to be highly effective, and produces relatively few side effects.

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CLINICOPATHOLOGICAL CONFERENCE

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the transverse colon. There were a few diverticulae of the descending colon, but otherwise no abnormalities of the colon up to the cecum which was adherent to an organized clotted mass in the right lower quadrant. The transverse colon and duodenum was slightly bound down to a hard retroperitoneal mass which was about 5″ in diameter. On exposure, this mass was found to be a large dissecting aneurysm of the abdominal aorta which had ruptured with drainage to the left side where a large organized thrombus was found. The wall of the aneurysm was necrotic and friable. Both iliac arteries were dilated and sclerosed. Gross diagnosis: Ruptured aneurysm of the abdominal aorta; generalized arteriosclerosis.'

The description of the aneurysm is not complete but the statement is made that it was a dissecting aneurysm. A dissecting aneurysm is, grossly, a quite definite entity and I think we must accept that diagnosis.

Aneurysm is usually the result of one of three causes. One of these is syphilis. This possibility cannot be entirely elminated in this case. The Wassermann report could not be found. The patient is young enough to fall in the age group when syphilitic aneurysm is more common. However, syphilitic aneurysm usually involves the arch of aorta and rarely the abdominal aorta. But the most conclusive evidence against syphilis is the fact that syphilitic aortitis does not result in dissecting aneurysm.

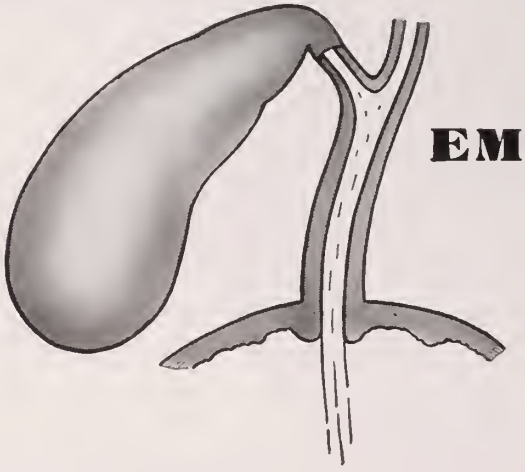
Atherosclerosis is the second cause of aneurysm. This does occur more often in the abdominal aorta. The protocol does not describe any atherosclerosis of the aorta, but does mention it in the iliac arteries. The patient is rather young to have much atherosclerosis. Again, while dissecting aneurysm may result from this cause, it is not usual.

The usual cause of dissecting aneurysm is given the descriptive name of 'idiopathic, medial, cystic necrosis'. The etiology is obscure. The condition is largely a degeneration of the elastic tissue of the media with the accumulation of a peculiar mucoid material in the tissues and later the formation of small cyst-like cavities.

Hemorrhage occurs into the weakened media, probably usually from a ruptured vasa vasorum. The pressure of this blood is sufficient to split the media for some distance so that sometimes there is a new formed channel extending the entire length of the aorta.

The usual termination is for the aneurysm to rupture through the adventitia. This usually occurs in the upper portion with hemorrhage into

continued on page 294



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HOSPITAL ASSOCIATION OF RHODE ISLAND

DIVISION OF TUBERCULOSIS CONTROL

R. I. State Department of Health

THE Tuberculosis control division of the Department of Health has as its function, the discovery, isolation, treatment, education, and rehabilitation of all individuals suffering from tuberculosis.

The case finding unit of this division has been expanded in the past two years. Its offices are located in the State Office building in Providence. It is staffed by a clinical director, clinic physician, public health nurses, photo-fluorographic operators and office personnel. In cooperation with district nursing associations and private physicians, it operates case finding and follow up clinics in the various towns and cities outside of Providence. In the City of Providence this work is done by the Tuberculosis Division of the Providence Health Department and the Providence Tuberculosis League. The League also conducts school and Industrial surveys in the city.

In the chest clinics individuals exposed to tuberculosis are examined and periodic examinations are also made of patients discharged from the sanatorium. In all of these clinic x-ray services are provided. Where local facilities are available for taking chest films these are utilized. This unit also provides advisory and consultation help for pneumothorax centres located in Newport, Westerly, Cranston and Warren. These refill centres are staffed by local physicians trained to do artificial pneumothorax. In the office a central registry of all cases of tuberculosis in this state has been set up. Information flows back and forth between this office and the various cities and towns.

The Divison conducts mass case finding surveys in schools and industrial plants outside of Providence. Lately it has been using the new miniature film technique which utilizes 70 mm. film with rapid filming methods. In spite of the fact that all the equipment needed has not yet arrived, about 12,500 miniature films of the chest were made in 1946. This unit is actively engaged in promoting the use of miniature filming for routine studies of the chests of all admissions to general hospitals and hospital personnel. Several hospitals have already installed these units and others are preparing to do so in the future. This office is ready to help all hospitals in planning such installations.

A bus fully-equipped with miniature filming apparatus is on order and when it is delivered the work of this group will be greatly expanded. It might be well to point out here that a similar bus was purchased several years ago by the Providence Tuberculosis League and it has done much of the pioneer work in mass Surveys in Providence. This unit also provides consulting nursing service in tuberculosis for the various nursing organizations throughout the state. It is also planned to conduct mass surveys in communities throughout Rhode Island. Such a survey is to be held shortly in Warren, with the cooperation of a committee of local people including business men, clergy, schools, clubs, etc.

The State Sanatorium is another unit of this division of tuberculosis control. It is situated in the town of Burrillville at Wallum Lake, twenty-five miles from Providence. It has been in existence since 1905 and provides sanatorium care for all forms of tuberculosis, and all ages are admitted by application to the superintendent. It has a rated bed capacity of 611 of which adults beds comprise 548, including 13 beds on the surgical ward. There are 63 beds for children and although in recent years the demand for children's beds has been scant, in the latter half of 1946 and early 1947 there has been an increased number of admissions to this ward. This has occurred in spite of the fact that it is believed in some quarters that tuberculosis in children has been on the decline.

The total patient census at this writing is 355. We have a list of 35 awaiting admission. Beds are unoccupied because there is a critical lack of trained nursing help. Since the majority of patients seeking admission to the sanatorium require bedside care, there is no point in admitting patients and then not being able to give proper care with trained personnel. The dietary department has been seriously crippled by the shortage of trained help resulting in great difficulties in proper food service.

continued on page 288



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DIVISION OF TUBERCULOSIS CONTROL

continued from page 286

The Sanatorium is fairly well equipped to provide all modern methods in the treatment of tuberculosis. It has a resident medical staff and complete facilities such as clinical laboratory, x-ray, pharmacy, occupational therapy, social service, dental service, physiotherapy, rehabilitation, library, and recreational facilities for patients. It has a school for children up to 12 years of age. For the older group educational facilities are rather sketchy but there is hope of enlarging this scope of this work in the future. In 1946 there were 278 admissions to the sanatorium with 55 per cent of the patients in the far advanced stage of tuberculosis. There were 30.9 per cent in the moderately advanced stage and only 9.3 per cent in the minimal stage. When we estimate that about 70 to 80 per cent of far advanced cases are dead in five years, it does not present too pretty a picture.

Artificial pneumothorax is the most used form of treatment. About half of the patients receive this form of therapy. A total of 15,374 pneumothorax refills were given in 1946. Pneumoperitoneum was given to 26 patients. Thoracic surgery such as thoracoplasty, pneumolyses, etc., were done to a total of 135 procedures. Bronchoscopy is being done more routinely in all sanatoria because of increasing knowledge of endobronchial tuberculosis. At Wallum Lake 157 bronchoscopies were done last year. The Sanatorium has an active visiting staff for the various specialties such as orthopedics, genito-urinary, eye, nose and throat, etc. There is also an active outpatient service for those patients who need pneumothorax refills and are unable to obtain them close to home. It is hoped that more refill centres will be established in other parts of the state. The facilities of the sanatorium are available to private physicians who may want help in their chest problems. Last year 708 patients were referred for this service.

The division of Tuberculosis control works closely with other related agencies in helping solve the tuberculosis problem. Members of the staff are available for lectures and talks before medical and lay groups. It is our hope that with the improvement in the help situation the Division may be able to rebuild its fences and carry on more efficiently not only in improving present services but to expand facilities so that a first class chest service may be made available to all who need it.

Members of the medical profession, hospital association and allied agencies are most cordially invited to visit the sanatorium and acquaint themselves with with what it has to offer.



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. . . clinical rickets in 37% of 9-months-and-less infants.[1]

. . . signs of rickets in 90% of a group of pre-school children.[2]

. . . histologic evidence of rickets in 46.5% of a group aged 2 to 14, with a peak of 62% in the 10 to 11 year group.[3]

. . . dental cavities twice as frequent in 5 to 15-year old children not on vitamin D as in those receiving it.[4]

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. . . "by the tenth or twelfth day of life, vitamin D in a concentrated form . . . should be started."[5]

. . . administer vitamin D prophylaxis "... from the second week . . . until maturity . . . "[6]

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ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

DISTRICT SOCIETY MEETINGS

BRISTOL COUNTY MEDICAL ASSOCIATION

A meeting of the Bristol County Medical Association was held on Tuesday, March 18, at 9 p. m. in the Bristol District Nursing Association offices with Dr. Marcius Merchant presiding.

The Secretary read the minutes of the previous meeting and reported that the Council and the House of Delegates of the Rhode Island Medical Society had approved of the chartering of the Bristol County Medical Association as a component unit of the State Medical Society.

The President introduced Mr. John E. Farrell, Executive Secretary of the Rhode Island Medical Society. Mr. Farrell expressed the procedures necessary for the drafting of a Constitution and set of By-Laws for the Association to be consistent with the regulations of the State Medical Society under which the charter has been granted. He explained in detail the provisions of a proposed constitution and by-laws and he recommended that a Councillor and Delegate be chosen to represent the Association at the meetings of those bodies in the near future.

Dr. Frank A. Merlino of the State Tuberculosis Department was introduced by the President and he showed two motion pictures outlining procedures for mass X-ray programs in industrial plants and in hospitals. Dr. Merlino also reported on the program that has been carried forward by the Tuberculosis Division of the State Health Department in Bristol County.

After the showing of the motion pictures the business meeting of the Association was resumed and there was discussion of plans for an annual dinner to be held some time in June.

A vote was taken for a Councillor and a Delegate to the State Medical Society and Dr. Arcadie Giura was named Councillor and Dr. Hubert Holdsworth was named Delegate.

The other officers of the Association previously elected are as follows:

President ..... MARCIUS MERCHANT, M.D.
Vice President ..... ULYSSE FORGET, M.D.
Treasurer ..... C. PAUL BRUNO, M.D.
Secretary ..... SAMUEL D. CLARK, M.D.

The meeting adjourned at 11 p. m.

Respectfully submitted,

SAMUEL D. CLARK, M.D.,
Secretary

NEWPORT COUNTY MEDICAL SOCIETY

The annual meeting of the Newport County Medical Society was held at the Newport Hospital on January 28, 1947. The meeting was opened at 9:05 p. m. with Dr. Alfred M. Tartaglino presiding.

The minutes of the November meeting were read and approved.

A communication from the Executive Office of the Rhode Island Medical Society called attention to the resignation of Dr. Philip S. Geller from the Rhode Island Medical Society was read and placed on file.

In response to a letter from Dr. Charles L. Farrell, in reference to an essay contest for school children, a discussion was held. Dr. Norman M.

continued on next page



MARCIUS H. MERCHANT, M.D.
First President
Bristol County Medical Association
1947

NEWPORT COUNTY SOCIETY MEETING

continued from preceding page

MacLeod stated that he felt that the school authorities were not particularly in favor of holding such contests and the motion of Dr. Samuel Adelson, to appropriate money for a prize for such a contest, was withdrawn.

A letter was presented by Dr. Louis E. Burns from Dr. Michael F. Walsh, Director of Instruction in the Newport School Department regarding the supplying of a visiting teacher for children confined to their homes by illness. He also requested an opinion on the advisability of immunizing children against diphtheria, prior to school entry. A motion was made by Dr. Norman M. MacLeod to send a letter to the school committee requesting that a visiting teacher be supplied for children confined to their homes by illness. Motion was seconded by Dr. Samuel Adelson and passed. A motion was made that the letter be sent to the school authorities, the local board of health, and the state board of health recommending that legislation be enacted to make diphtheria immunization a prerequisite to school entry.

The following slate of officers was then elected for the ensuing year:

President ..... Alfred M. Tartaglino, M.D.
1st Vice President ..... William A. Stoops, M.D.
2d Vice President ..... Philomen P. Ciarla, M.D.
Secretary ..... Henry W. Brownell, M.D.
Treasurer ..... Norbert U. Zielinski, M.D.
Delegates ..... Louis E. Burns, M.D.
James C. Callahan, M.D.
Councillor ..... Samuel Adelson, M.D.
Censors ..... Norman M. MacLeod, M.D.
John A. Young, M.D.

The speaker of the evening, Dr. Meyer E. Saklad, Chief of the Department of Anesthesiology at the Rhode Island Hospital, was then introduced. Taking as his subject, "The Present Day Status of Anesthesia," the speaker gave an extremely interesting and informative talk on the organization of his department at the Rhode Island Hospital, the type of procedures carried on by the department, in addition to strictly anesthetic administration, the selection of anesthetic agents for various types of surgical procedures, and the advantages and disadvantages of the several agents.

Following his presentation, which was illustrated by lantern slides, there was a general discussion and question and answer period.

A collation followed.

Respectfully submitted,
Henry W. Brownell, M.D.,
Secretary

PROVIDENCE MEDICAL ASSOCIATION

The meeting of the Providence Medical Association called for Monday, February 3, 1947, was a joint meeting with the Rhode Island Medical Society.

The meeting was called to order by Dr. Herman C. Pitts, President of the Rhode Island Medical Society, at 8 p. m. Dr. Pitts reported that there would be a brief meeting of the members present who are members of the House of Delegates, immediately upon the adjournment of the meeting. He also reported that the Woman's Auxiliary would hold an organization meeting at the Medical Library on Wednesday, February 5, at 3 p. m., and he urged that members request their wives to be present.

Dr. Pitts introduced as the first guest speaker of the evening Dr. Lewis C. Schaffey, Professor of Obstetrics and Gynecology at Jefferson Medical College and Hospital, in Philadelphia. Dr. Scheffey spoke on the subject, "The Role of the General Practitioner in the Early Diagnosis of Pelvic Cancer."

The two major errors in diagnosis are the reticence of women and the indifference of the family doctor.

In carcinoma of the pelvis he stated that the uterus is the most common site with ovaries next and vagina and tubes third.

Early diagnosis can be made by careful history, attention to cases of long standing therapy and long standing indigestion; adequate means of examining the pelvis; and repeated periodic examinations.

He stated that in Philadelphia cases are studied to see where the slip was, then the doctor is called in and goes over the case. He then showed slides demonstrating the various stages of carcinoma of the uterus. He then showed slides of various phases of vaginal smears and smears showing cancer cells. These vaginal smears made the correct diagnosis in 80 per cent of the cases examined.

Dr. Guy W. Wells, President of the Providence Medical Association, introduced the second guest speaker of the evening, Dr. Chester M. Jones, Clinical Professor of Medicine at Harvard University and Physican at the Massachusetts General Hospital. Dr. Jones spoke on, "The Diagnosis and Treatment of Liver Disease, With Special Reference to Liver Biopsies."

The diagnosis of liver disease is now made in definite terms of what is going on in the living liver and this gives us clues as to treatment.

In many instances laboratory studies cannot tell us what is going on at the time we are treating the patient. With liver biopsy treatment will be more simple rather than complicated.

continued on page 294



Eminent critic . . . . . dietary dub!

At meal time his renowned judgment deserts him. Eating only the food he likes, a choice of notably limited range, he thrice daily produces a burlesque on proper nutrition. Inevitably, this perennial first-nighter makes his entrance into some physician's reception room—the victim of a self-made, borderline vitamin deficiency. In the same cast, you will find other familiar types. Included in it are the ignorant and indifferent, people "too busy" to eat properly, those on self-imposed and badly balanced reducing diets, excessive smokers, food faddists and alcoholics, to name a few. First thought in such cases is dietary reform, of course. Along with that, a dependable vitamin supplement may well be in order. When you prescribe an *Abbott* vitamin product, you are assured that the patient will receive the full vitamin potencies intended. Your pharmacy carries a complete line of Abbott vitamin products in a variety of dosage forms and package sizes, and will be pleased to fill your prescriptions. ABBOTT LABORATORIES, NORTH CHICAGO, ILLINOIS.

SPECIFY

Abbott Vitamin Products

PROVIDENCE MEDICAL ASSOCIATION

concluded from page 292

Liver disease is now treated by replacement therapy—proteins, choline, vitamins, etc. The liver cells form albumen for the blood. Liver disease is treated with albumen—this gives diuresis and ascites disappear.

In acute intrahepatic disease the whole count can go up to 30,000 and the temperature is elevated too. Infectious hepatitis is a virus disease caused by food or by plasma infusion. The onset is abrupt with fever, jaundice and leucopenia. It is a self limited disease. Most do well.

Dr. Jones then showed excellent pathological slides obtained by punch biopsy showing various stages of liver disease. He then described the technique for performing liver biopsy. If the liver is enlarged it is done anteriorly while the patient holds his breath. If the liver is small it is done posteriorly during deep expiration. In over 200 cases, only one fatality occurred.

Attendance, 172.

Collation was served.

Meeting adjourned at 10:20 p. m.

Respectfully submitted,

DANIEL V. TROPPOLI, M.D.,
Secretary

CLINICOPATHOLOGICAL CONFERENCE

concluded from page 284

the pericardial cavity or into the mediastinum. In this case the rupture occurred in the abdominal aorta.

Sometimes the new formed cavity ruptures back into the aorta lower down and it may then heal, leaving a smooth-lined channel through which the blood flows: double aorta.

In trying to correlate the pathology with the clinical story there are two things that might be suggested. (1) The history of hemorrhage from the gastro-intestinal tract must be discounted. No such bleeding was observed during nine days in the hospital. The patient's history must be regarded as unreliable. (2) The pain deserves more attention. It was of sudden onset and from then on was intractable. Dissecting aneurysm is one of the causes of such pain."

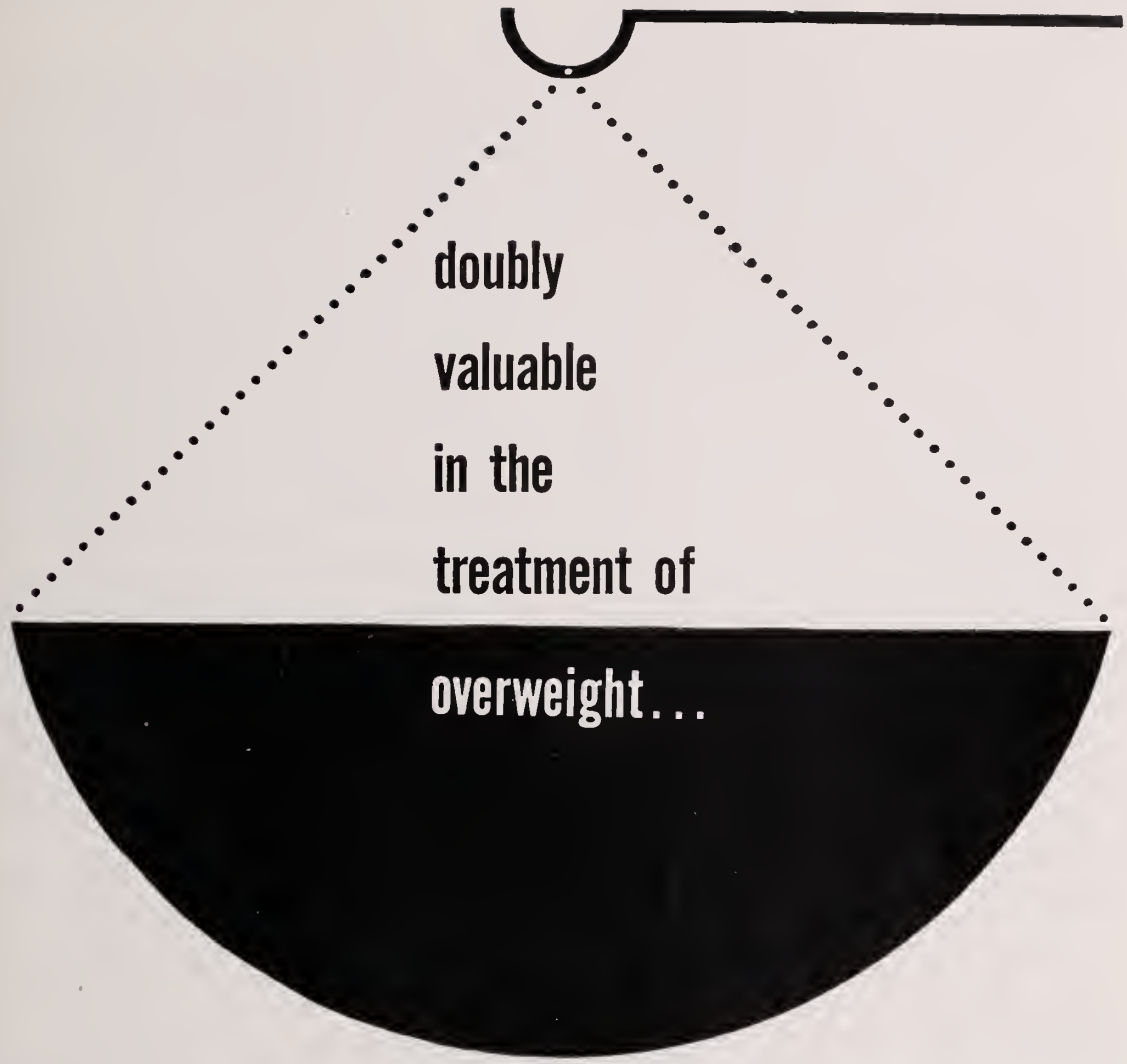
NEXT MEETING . . .

Providence Medical Association

MONDAY, MAY 5

at the Medical Library





In a recent clinical study, Hawirko and Sprague* found that *Dexedrine* (*d*-amphetamine) exerts two beneficial actions in the treatment of overweight:

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2. Its unique central nervous stimulant effect combats the feeling of "discouragement and irritability which usually accompanies rigid adherence to prolonged use of a low calorie diet".

*Canad. M. A. J. 54:26 (Jan.) 1946

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ABSTRACTS FROM THE REPORT ON THE RHODE ISLAND STATE DEPARTMENT OF HEALTH AS PREPARED BY GRIFFENHAGEN & ASSOCIATES OF CHICAGO*

SUMMARY OF RECOMMENDATIONS

The major recommendations embodied in this report can be summarized as follows:

As to Organization:

1. Reorganize the existing 16 divisions and other agencies in the department of health into the following seven divisions:
   Division of Administration. Division of Communicable Diseases. Division of Laboratories. Division of Environmental Sanitation. Division of Maternal and Child Health. Division of Public Health Nursing. Division of Tuberculosis.

   Under this organization each of the chiefs of the divisions would constitute the staff of the director of health on matters of internal policies and plans, liaison with other agencies, and coordination of activities. The existing advisory council, renamed the public health council, would be given advisory and hearing functions, without administrative or executive power, in addition to its present function of aiding the director of health on external relations and in the formation of rules and regulations, and broad department policies.
2. Activities of existing agencies in the department would be disposed of as follows:
   Certain activities would be discontinued. Certain activities would be transferred out of the department of health to other state agences. Certain existing activities would be expanded. Certain new activities would be added.

   The recommended reorganization plan, embodied in the text of the report, indicates the allocation of all retained, expanded, and new activities among the seven divisions.
3. Make the position of director of health a full-time career position under civil service, with a five year term at a salary of $10,000 per annum. Prohibit private practice of medicine by the director of health.
4. Abolish the position of legal counsel.
5. Replace the existing division of business management with a division of administration, headed by a qualified top specialist in public health administration who would also be the deputy director of health. This division would deal with district or local public health services, public health education, vital statistics, professional regulation, and intra-department administrative services. The existing divisions of business management would then be redesignated the administrative services section of the division of administration.
6. Create a position for a qualified public health educator who, under the deputy director of health, would coordinate all matters of public health education, public relations, and publicity for the department.
7. Provide additional facilities and personnel for vital statistics activities and particularly for essential research in vital statistics.

As to Existing Units in Internal Organizations:

8. Abolish the cancer prevention clinic and bureau of cancer control. The cancer reporting laws should be repealed. The residual function of the existing bureau of cancer control concerning authorization of hospitalization for indigent cancer patients should be made a responsibility of the proposed deputy director of health.
9. Transfer the toxicology laboratory out of the department of health.
10. Abolish the following existing laboratories, the pathology laboratory, food and drug laboratory, and the diagnostic chemistry laboratory together with all of their services except the analysis of foods allegedly unfit for human consumption.
11. Centralize all existing independent laboratories and all activities pertaining to the distribution of biologicals, sera, drugs, and pharmaceuticals in the division of laboratories.
12. Establish a research laboratory.

* Taken from the complete report of the Commission to Re-Examine the Field of Governmental Operations, the Cost of Governmental Services, and the Tax Structure of the State, February, 1947.

13. Transfer commercial food frauds activities from the division of food and drug control to some agency outside the department of health and then eliminate the division of food and drug control by intra-departmental reallocation of all other functions of the division.
14. Expand the industrial hygiene program.
15. Give increased emphasis on the importance of the public health nursing function to the public health program by changing the name of the bureau of public health to the division of public health nursing.
16. Abolish the bureau of recreational safety.

As to Policies and Procedures:

17. A full study should be made of all laws pertaining to professional and trade regulatory bodies, with a view to revising such laws so as to strip all such bodies of administrative power, and to limit their authority to examination and approval of candidates, the hearing of complaints of violations of license restrictions, and advice to the director of health. Exclusive power should be vested in the director of health to issue, suspend, or review licenses for all professions or trades now under the jurisdiction of the department, as well as the sole right to make all sanitary inspections.
18. Vest exclusively in the department of health jurisdiction over milk control by eliminating the overlapping function of the department of agriculture with respect to milk control.
19. Transfer the authority to license maternal hospitals and homes from the children's service division of the department of social welfare to the division of maternal and child health of the department of health.

As to Internal Policies and Procedures:

20. Provide for compilation and publication of annual reports of the department for the years subsequent to 1940. Provide also for prompt compilation and publication of all future annual reports of the department.
21. Give specific duties to the advisory council and make provision for frequent and regular meetings of the advisory council. All practicable measures to strengthen the advisory council should be taken.
22. Develop and publish standard procedures on matters pertaining to administrative services, internal organization, policies and procedures, and provide a method for keeping such procedures up-to-date for the information and guidance of department employees.
23. Hold frequent and regular meetings of the staff of the director and encourage the staff to become an effective instrument for aiding the director in coordinating the activities of the department and assuring positive action on department plans.
24. Provide means for assuring more effective planning of the broad, overall program of services to be rendered by the department.
25. Provide additional space and personnel for the department library.

As to Personnel:

Salaries in the department of health are inadequate to permit the divisions to be fully staffed. No detailed conclusions on salaries can be reached without a full study of comparative salary scales which would require considerable more time than has been made available for the present study. A spot check of salaries in individual positions indicated that salaries in the department of health, in the instances selected, ranged from 10 per cent to 33⅓ per cent below comparable salary scales in other states.

26. Firm administrative action should be taken to discourage indicated abuses of the sick leave privilege and consideration should be given to the imposition of a limitation on the total amount of permissible accumulation of vacation leave as a possible means of discouraging abuse of the sick leave privilege.

As to Local Public Health Services:

27. Provide for the extension of the existing bedside nursing care furnished by public health nurses assigned to the department of health to those few towns where no suitable local facilities are available.
28. Centralize all local public health services in the State of Rhode Island under the direction and control of the director of health as a means of securing uniform services and service of better quality than are now available, notwithstanding the fact that there is scant hope of affecting any reduction in the total amounts now expended by both the state and the local governments and local public health services because the present expenditures are so far below the recognized amounts required to provide minimum basic services.

    Provision should be made in such centralization for participation by local municipalities in the cost of local public health service either on a basis of a flat rate of $1 per capita or on a basis of an even split of the total costs, the municipalities share being apportioned according to population.

continued on next page

It is estimated that the proposed centralization of local public health services will require an expansion of the existing field staff of the department of health from 32 to 216 people. It is further estimated that the cost of providing this staff will be about $550,000 a year and that administrative overhead and special local program costs will be determined by the policy adopted with regard to the scope of services to be rendered.

As to Facilities and Equipment:

29. Provide additional office space for the activities of the department of health. Provide additional required equipment as indicated.

* * * * *

Scope of the Public Health Problem in Rhode Island:

The total population of the State of Rhode Island is about 725,000, but the greater majority of this population is concentrated in the extreme northeasterly section of the state. About 52 per cent of all persons gainfully employed in the state work in industrial plants.

There were 39 units of government; 32 towns of varying sizes and 7 cities: Providence, Pawtucket, Woonsocket, Cranston, Newport, Warwick, and Central Falls. While each town and city has a health officer, only the cities of Providence and Pawtucket maintain full-time health departments and only five other communities provide any substantial local public health services. There are five counties in the state but they play no significant part in the government.

Geographically, the State of Rhode Island is very compact and it is possible to reach almost any part of the state from any other part in about an hour's time.

The small size and high population density make Rhode Island ideally suitable for centralized public health administration and should permit the state to excel in the quantity and quality of public health services.

Functions and Activities:

The responsibility of the state in matters of public health rests upon a broad concept of the meaning of public health. Lacking this, there can be no sharp focus of effort on public health problems, and the organization established to protect the public health may find its force dissipated in medical care of the sick and other activities of great intrinsic worth or popular appeal which have little or no relation to public health.

Public health services consist of the application of the services of preventive medicine through government for social ends. Public health is concerned with conditions, usually arising out of personal conduct or the use of property, which jeopardize the health of the public at large. Private health, on the other hand, is concerned with conditions that affect the health of particular individuals but constitute no threat to the health of the general community. Seldom, if ever, can individual action abate a threat to the health of the public at large and the state consequently exercises its inherent powers as a sovereign to control such conditions either by the exercise of the police power or through education of the public.

The present functions of the Rhode Island department of health are:

1. To provide a complete public health program at the state level.
2. To take all action necessary for the protection of the lives and health of the citizens of the state, regardless of specific provisons of statutes.
3. To correlate the public health activities of all federal, state, municipal, and private agencies in so far as they deal with matters of public health in the State of Rhode Island.

* * * * *

Weaknesses in Existing Organization Structure: There are two principal weaknesses in the existing organization structure of the department of health.

The first major weakness in the existing organization structure is the presence, in the department of health, of agencies having functions, in whole or in part, which do not pertain to public health. The bureau of recreational safety is an example. Such extraneous functions, in so far as may be practicable, should be eliminated or transferred, as the situation requires.

The second major weakness is the presence of too many subordinate divisions and other agencies for effective administrative control. In place of a strong, well integrated department, capable of executing and administering broad plans for public health services, there exists a collection of semi-autonomous agencies subject to little overall guidance and direction. Although the director of health is required by law to administer the department, the fact that he has 20 division heads and key people reporting to him makes it virtually impossible to achieve effective results. A regrouping of existing agencies into as few major divisions as possible is clearly indicated.

* * * * *

Proposed Organization Structure of the Department of Health:

Regrouping of Existing Divisions and Agencies: It is recommended that the existing agencies of

continued on page 301

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HEALTH DEPARTMENT STUDY

continued from page 298

the department of health be regrouped into seven divisions as follows:

Division of Administration. Division of Communicable Diseases, Division of Laboratories. Division of Environmental Sanitation. Division of Maternal and Child Health. Division of Public Health Nursing. Division of Tuberculosis Control.

Staff of the Director of Health: The chiefs of each of the seven proposed divisions should, in addition to their administrative duties, serve as the staff of the director of health. As such they should be concerned with matters of internal policy, including coordination and integration of the activities of the divisions; the allocation of available funds to the various department activities in accordance with the requirements of the overall department plan and program; and coordination with state, Federal, and other official agencies, and with private agencies, on execution and administration of plans and programs for public health services.

Proposed Division of Administration: The contemplated functions of the proposed division of administration are considerably broader than those of the existing division of business management, although the functions of the latter body are intended to be assigned to the proposed division. The chief of the proposed division of administration should be a qualified top specialist in public health administration and would be in effect the deputy director of health.

This proposed division would be charged with responsibility for the following activities:

1. Provision of district or local health services. 2. Public health education. 3. Administration of the cancer control program. 4. Compilation and analysis of vital statistics. 5. Professional regulation and issuance of licenses. 6. Provision of central administrative services for all agencies of the department of health, except the proposed division of tuberculosis. 7. Maintenance of the department library.

The division would operate through the following sections:

District and local public health services: This section would perform the functions now generally discharged by the division of district public health administration.

Public health education section: This section would be responsible for all matters of public relations and for executing plans for education of the general public in all public health matters. At the present time this function is scattered among the different existing agencies with a consequent loss of effectiveness. All publicity emanating from the department should be cleared by, and issued from, this section.

This section would also be responsible for administration of those functions of the present bureau of cancer control which are retained.

Vital statistics section: This section would be charged with compilation and maintenance of all records of births, deaths, and marriages currently charged to the division of vital statistics. In addition, it would produce necessary statistical data from such records.

Professional regulation section: This section would perform all of the functions of the present division of professional regulation with the board of hair-dressing merged therein.

Administrative services section: This section would perform the administrative services of a budgeting, accounting, personnel, and other general administrative nature now furnished by the division of business management, provide central mail and messenger services, and would maintain the department library.

Proposed Division of Communicable Diseases: The proposed division of communicable diseases would perform all of the functions of the existing

continued on next page



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HEALTH DEPARTMENT STUDY
continued from page 301

division of communicable diseases and would function through a venereal disease control section and an epidemiology section.

Proposed Division of Laboratories: The proposed division of laboratories would perform all of the functions of the existing division of laboratories and the laboratory functions of the existing divisions of sanitary engineering and industrial hygiene. Distribution of sera, vaccines, and drugs, now handled by the division of communicable diseases and the division of food and drug control, would be assigned to the proposed division of laboratories.

The proposed division of laboratories would be organized with a section for each separate laboratory, a section for the distribution of drugs, sera, and vaccines, and an office administration section. Certain existing laboratories and laboratory services, as described more fully later in the report, would be abandoned.

Proposed Division of Environmental Sanitation: The proposed division of environmental sanitation would include all of the functions currently performed by the existing divisions of sanitary engineering and industrial hygiene, other than laboratory services, and the retained functions of the division of food and drug control.

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The proposed division would function through the following sections:

Water and milk section; Sewage and shellfish section; Sanitary inspection section; Industral hygiene section.

The retained functions of the present division of food and drug control would be assigned to the proposed sanitary inspection section. The functions of the present division of industrial hygiene, other than laboratory functions, would be performed by the proposed industrial hygiene section. The present functions of the existing sections of the present division of sanitary engineering would be performed by the proposed sections of similar designation, except that the laboratory functions would be transferred to the division of laboratories.

In so far as the industrial hygiene section deals with the medical detection of disease, there must be parallel responsibility between the medical director, industrial hygiene; and the public health engineer who heads the proposed division of environmental sanitation in order to avoid any possibility of a sharp conflict in professional interests. Development of a suitable working arrangement to this end is a tacit assumption in the proposal to combine the present division of industrial hygiene with the present division of sanitary engineering.

Proposed Division of Maternal and Child Health: The proposed division of maternal and child helath would perform all of the functions now exercised by the present division of maternal and child health, and services to crippled children.

Proposed Division of Public Health Nursing: The present bureau of public health nursing would be renamed and would constitute the proposed division of public health nursing.

Proposed Division of Tuberculosis Control: The existing division of tuberculosis control and the Rhode Island state sanitorium would be renamed the division of tuberculosis control.

Functions to be Eliminated or Transferred: Certain functions now exercised by existing agencies of the department of health would either be eliminated entirely or transferred out of the department under the proposed plan of organization. Such functions are described later in this report under a heading for each such agency.

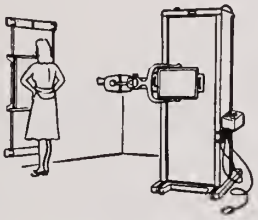
Existing Units of Internal Organization of the Department of Health:

Office of the Director: The director, appointed by the governor for a term of two years with an annual salary of $6,000, is the chief executive officer of the department. While the position is considered to be a full-time job, the state cannot expect that any person appointed to this position will cut himself off from the possibility of return-

continued on page 304

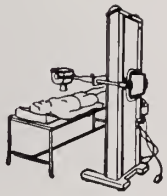
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HEALTH DEPARTMENT STUDY

continued from page 302

ing to private practice at the expiration of the term.

* * * * *

The director of health has great responsibility and his power to protect the public health, which is equally great, in many respects exceeds the power of the courts of the state. The position is of such importance that a full-time head is indispensable. The task of safeguarding the health of the state is certainly as important as that of administering justice and should be compensated accordingly. Provision of a salary of $10,000 per annum (which is the same as the salary received by a justice of the superior court), an extension of the term from two to five years, and provision for appointment pursuant to the provisions of the classified civil service, should offer sufficient inducement to a qualified public health administrator to devote full time to the position. Until such adjustments are made, it can be expected that any person appointed director of health will continue to consider his personal interests even though they may only be satisfied at the expense of the public interests. It is recommended that the existing statutes be amended to provide that the position of director of health shall be a full-time position under the provisions of the classified civil service, that all private practice of medicine be excluded, that the term be extended to five years, and that the salary be increased to $10,000 per annum.

The director of health is charged not only with formulating plans for protecting the public health but also with executing and administering such plans. At the present time there does not appear to be that degree of planning and coordination of execution and administration of plans, that is believed to be essential to securing the most effective results. The recommendations with respect to organization structure, increase of salary, civil service appointment, and longer term of office of the director are considered essential prerequisites to any improvement in this respect. It should be noted, however, that firm and vigorous leadership is equally essential.

* * * * *

Division of District Public Health Administration: Field public health services are rendered by three district units, each of which is autonomous, and which together comprise the so-called division of district public health administration under the immediate direction of the director of health. These units render local public health services but the services are not uniform in each community nor are they fully effective in meeting the minimum basic requirements for such services. The district units furnish only venereal disease control services to the cities of Providence and Pawtucket. Most of the local public health services in the city of Woonsocket are furnished by a district unit. Public health services are provided for other cities and towns in varying degrees according to local demand for services, local cooperation, and available state funds.

* * * * *

Division of Professional Regulation: The division of professional regulation was established in 1944 by the director of health, to discharge the statutory authority vested in the director of health with relation to various professional and trades regulatory agencies, and to render central services for such agencies. There are 13 boards and one committee included in the division. The boards vary in size from three to five members. The members in most cases are appointed by the director of health with the approval of the Governor, but the Governor appoints the members of the state board of plumbing examiners. Terms of office are for the most part indefinite although specific terms are provided for members of five of the boards.

The committee on nursing education consists of ten members appointed by the director of health for overlapping terms of five years and the director of health, ex-officio.

Each board has the power to examine, license, and register candidates for the particular profession or trade concerned. In some cases, however, particular boards have been given independent administrative power such as the right to revoke or suspend licenses. The law creating the board of barber examiners provides that sanitary inspections of barber shops can only be made by a licensed barber. These and similar provisions of law are a threat to democratic government, since the power is not given by law for the good of the public but for the good of special interest groups. A full study should be made of all of the laws pertaining to these professional and trades regulatory boards with a view to limiting their authority to examination and approval of candidates, the hearing of complaints of violations of license restrictions and ad-

continued on page 307

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HEALTH DEPARTMENT STUDY

continued from page 304

vice to the director of health. The director of health, however, should have the power to issue, suspend or revoke al licenses as well as the power to make all sanitary inspections.

* * * * *

Division of Communicable Diseases: The function of the division of communicable diseases is to prevent and suppress the spread of communicable diseases. Its activities include:

1. Collection of morbidity reports. 2. Cooperation with local health officials. 3. Investigation of sources and means of transmission of communicable diseases. 4. Administration of a venereal disease control program. 5. Health education in conjunction with communicable diseases.

* * * * *

The functions of this division are of such major importance to public health as to justify a separate divison for their discharge. The division, however, distributes various drugs in connection with its venereal disease program. This activity should be transferred to the division of laboratories which, under the proposed plan of organization, would be the central distribution agency for all sera, drugs, and vaccines.

Bureau of Cancer Control: The bureau of cancer control was established in 1942 pursuant to statute. Its functions, as prescribed by the statute, are:

> "to formulate a plan for the care and treatment of indigent persons suffering from cancer, to establish and designate standard requirements for the organization, equipment, and conduct of cancer units or departments in general hospitals of this state . . . and to formulate and put into effect an educational plan for the purpose of preventing cancer, and for the purpose of aiding in the early diagnosis of cancer, and for the purpose of informing hospitals and cancer patients of the proper treatment."

The bureau of cancer control maintains statistical files of all cases of cancer reported in accordance with state law, conducts a cancer prevention clinic; furnishes hospital care for indigent persons suffering from cancer and conducts, to the limited extent possible with its present staff and funds, an educational program on cancer. The program is a concession to popular interest and the force of propaganda rather than an expression of a useful administrative or preventive service.

The cancer prevention clinic, as currently operated, is conducted one day a week in Providence. This is a general physical screening for women only. If a cancer is detected, the patient is referred to one of the tumor clinics operated by the private hospitals without benefit of state aid. It is expected that persons attending the cancer prevention clinic

continued on next page



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HEALTH DEPARTMENT STUDY

continued from preceding page

will report once every six months for an examination. Since each clinic can accommodate only 15 patients a day, it is obvious that the clinic can examine only 780 cases in the course of a year and the the policy of conducting examinations twice a year limits the services of the clinic to 390 women. Examinations are arranged by appointment and the clinics are now booked solidly until August 1947. It is obvious that the clinic, under this arrangement, serves an extremely limited purpose which hardly justifies its existence.

Apart, possibly, from industrial cancers, the causes of cancer are still unknown. It is doubtful if the collation of information on cancer cases in Rhode Island can furnish a sufficiently broad statistical base to throw effective light on the causes of cancer. Consequently cancer statistics serve little or no purpose. The law requiring the reporting of such statistics should be repealed.

The present staff of this division consists of a statistician and a clerk. The director of health is the acting medical director. While this position provides for a salary of $4,000 a year, the state cannot reasonably expect to employ a qualified cancer specialist for less than $10,000 a year.

The program in its present form, apart from subsidies for hospitalization of indigent cancer patients, is believed to be more shadow than substance. During the fiscal year ended June 30, 1946 the bureau spent $8,485.61 of which $5,724 was for hospitalization and treatment of 105 indigent patients.

Until the basic public health services are fully met, no program of such limited public health application as cancer control should be adopted. It is recommended that the cancer prevention clinic be discontinued. The continuation of hospitalization for indigent cancer patients is a matter of state policy and provision might well be made for this purpose.

Division of Laboratories: The function of the division of laboratories is the performance of toxicological, pathological, food and drug, chemical, serological, and bacteriological examinations, and analyses to aid in the diagnosis and control of preventable diseases and related problems.

* * * * *

The pathology laboratory is engaged in making free pathological examinations for private hospitals and a limited number of physicians. There is no reason why the state should furnish free pathological examinations since they pertain to private health and not to public health. The pathology laboratory should be abolished.

* * * * *

continued on page 310

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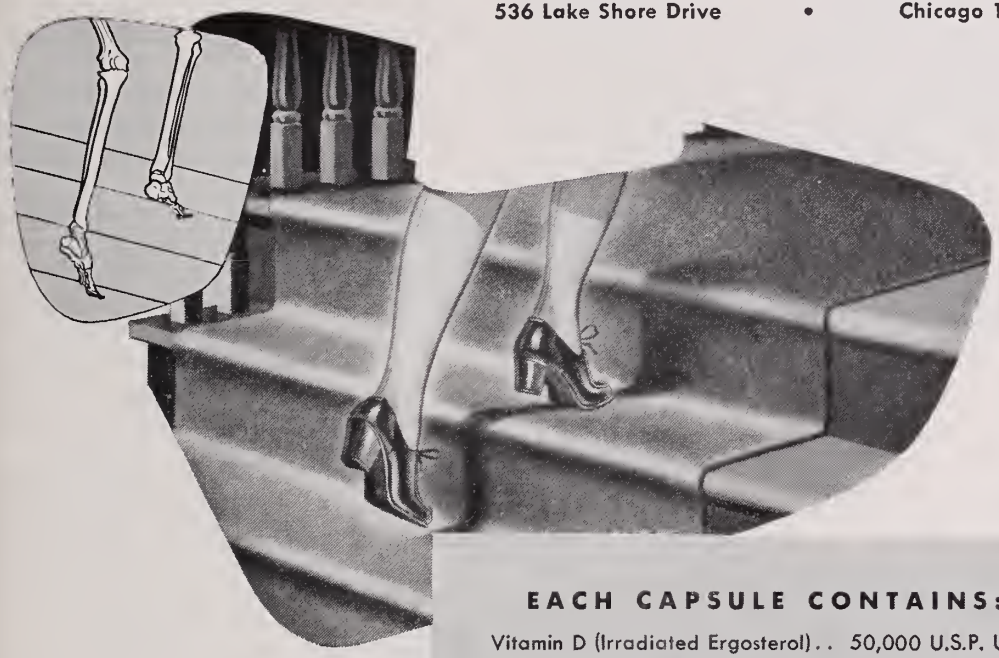
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HEALTH DEPARTMENT STUDY

continued from page 308

The diagnostic chemistry laboratory is engaged in making free blood chemistry examinations, urinalyses, and differential blood counts as a convenience for physicians in the immediate vicinity of the laboratory. This is not a public health function. It is estimated that this laboratory does 10,000 blood chemistry analyses, 25,000 urinalyses, and 4,000 differential blood counts in the course of a year. If the laboratory were conducted as a private enterprise this amount of work would be equivalent, on the basis of commercial charges, to a gross business of $60,000. Of course, it does not cost the state anything like that amount to operate this laboratory. However, there is no reason why the state should provide free services, not related to public health, in any case and certainly not on the present scale on which these free services are rendered.

* * * * *

Division of Sanitary Engineering: The function of the division of sanitary engineering is to assure adequate environmental sanitation.

* * * * *

Milk control is complicated by the fact that the department of agriculture exercises jurisdiction over milk production on the farm and relinquishes jurisdiction only when the milk has left the farm. Such divided control tends to defeat the purpose of milk control. Provision should be made to place such control exclusively within the jurisdiction of the health department.

A laboratory is maintained by the division for the analysis of milk and water. There is no reason why any division should maintain laboratory services separate and apart from the division of laboratories, and it has already been recommended that this laboratory be transferred to the division of laboratories.

* * * * *

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Division of Food and Drug Control: The division of food and drug control was created in 1935 by combining the existing agencies, known as the division of narcotic drugs and pharmacies, and the division of foods and drugs. The general functions of the division are:

1. To prevent illicit use of narcotics and similar drugs and eliminate drug addiction. 2. To protect the public against commercial food frauds. 3. To protect the public against commodities unfit for human consumption. 4. To prevent the promiscuous sale of dangerous drugs and poisons. 5. To distribute biologicals for use in immunizations, and blood plasma to physicians and hospitals. 6. to issue licenses to pharmacists and drug dispensers.

The function pertaining to narcotics is not related to public health but to police. This function should be transferred to the office of the attorney general.

The function of protecting the public against commercial food frauds is definitely not a public health function and should be transferred out of the department of health. It is not possible to state specifically in this report where this function should be placed. It is suggested, however, that either the office of the attorney general or the department of agriculture would be a more appropriate a place than the department of health.

The function of protecting the public against commodities unfit for human consumption is a public health function. It is, however, so closely allied to the food and beverage sanitation functions of the present division of sanitary engineering that it should be transferred to that division.

The function of preventing the promiscuous sale of dangerous drugs and poisons is partly a police function and partly a public health function. It, too, is closely allied to the food and beverage functions of the present division of sanitary engineering and should be transferred to that division.

The function of distributing biologicals should be transferred to the division of laboratories. The function of issuing licenses should be transferred to the present division of business management.

* * * * *

Division of Industrial Hygiene: The functions of the division of industrial hygiene are:

1. To study the problem of industrial health and occupational diseases in industry. 2. To determine the effect of employment on public health. 3. To conduct educational programs on the problems of industrial health.

* * * * *

The activities of this division are closely related to the division of industrial inspection of the department of labor.

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"Food allergies are more common in infants and young children than in later life" *

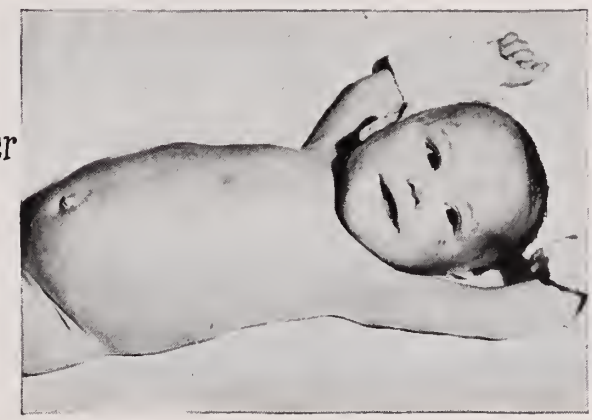
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*Levine, S. Z.: J.A.M.A. 128:283, May 26, 1945

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HEALTH DEPARTMENT STUDY

continued from page 310

There are 3,300 industrial plants in the State of Rhode Island. These are concentrated for the most part in the northeastern section of the state. Many of the plants have industrial hygiene sections, and 165 industrial nurses are employed throughout the state. Over 52 per cent of all persons gainfully employed in the state are employed in industrial establishments.

Because of this predominating industrial influence, which effects such a large percentage of the people of the state, the program of the division of industrial hygiene should be expanded and made more intensive than it now is. It is recommended that four additional field workers be authorized to aid in expanding the program of this division.

The present program of the division is pretty well limited to matters of education and public relations. Since August 1946 no field surveys have been made by the industrial hygiene engineer.

The division maintains its own laboratory for the analysis for toxicity of samples of industrial gases, fluids, and solids. This function should be transferred to the division of laboratories.

The functions of the division of industrial hygiene and those of environmental sanitation are so closely related that they should be merged with the division of sanitary engineering provided that a suitable working arrangement can be made for parallel responsibility between the medical director and the public health engineer on matters dealing with medical detection of disease.

Division of Maternal and Child Health: The functions of the division of maternal and child health are to protect the lives of mothers, infants, and children; to suppress diseases of children; and to improve the health of young children. The division's activities are supported materially by Federal grants. The division administers these Federal grants and coordinates the conduct of various programs in the field by the district public health units. Included in its present programs are the following:

1. A rheumatic fever treatment program subsidized for the most part with federal funds. 2. Emergency maternity and infant care subsidized entirely with Federal funds. 3. A dental care program primarily conducted in Woonsocket with the aid of Federal funds. 4. Nutrition consultation services. 5. Child health conferences. 6. Pre-natal and post-natal care. 7. Immunization of pre-school and school children.

* * * * *

The principal weakness in the division's program is the limited scope of its application. Activities are not conducted on a state wide basis. Particular parts of one activity appear to be overstressed, as for example, the immunization program is almost wholly devoted to diphtheria immunization. Considerable attention is devoted to the rheumatic fever program, evidently because of available Federal grants, notwithstanding the fact that rheumatic fever is not a communicable disease and is therefore a matter of clinical medicine rather than a matter of public health.

The division appears to be overstaffed with clerical workers. With a reduction in the emergency maternal and infant care program it should be possible to reduce clerical staff.

Division of Services to Crippled Children: The division of services to crippled children is charged with the function of aiding crippled children and children suffering from conditions which lead to crippling. Its activities are related to its functions. Federal grants furnish about half of the funds for its activities. The functions of this division do not relate to public health, but it is questionable whether Federal funds would be made available if the functions were transferred to another state department and the field service force of the department of health is well suited for assisting in activites of this nature.

The division has 9 employees, two of whom are part-time. Three of the employees actually work exclusively on the rheumatic fever program for the division of maternal and child health.

This division appears to be doing effective work. The close relationship of its functions to those of the division of maternal and child care would justify the consolidation of these two divisions.

Bureau of Public Health Nursing: The functions of the bureau of public health nursing are to provide and supervise all public health nurses engaged in performing activities in the department of public health. Activities of individual nurses in the districts are, for the most part, general and not special. Supervision of district nurses is maintained through a district supervisor public health nurse in each of the district public health units and supervision of other nurses is maintained through the chiefs of those divisions to which special nurses are assigned.

* * * * *

Bureau of Recreational Safety: The bureau of recreational safety was established by the director of health in 1937 and charged with the function of providing free life saving, rescue, and first aid services at privately owned public beaches. The division of forests and parks of the department of agriculture provides similar services for state parks and beaches.

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HEALTH DEPARTMENT STUDY

continued from preceding page

The bureau performs no public health functions. Since the division of forests and parks of the department of agriculture provides lifeguards for state operated beaches and parks, it is dubious whether this bureau in providing free lifeguard service for other than state beaches and parks serves a legitimate public function. Its functions should certainly be transferred to the division of forests and parks and they might will be eliminated entirely.

* * * * *

Program Planning: Little appears to have been done by the department of health in the way of planning a broad overall program of services. The availability of grants from the Federal government for specific purposes has been a factor of great influence in determining the existing program. In some cases this has enabled increases to be made in the staff but the application of this increased force hasn't been uniform throughout the state. Plans should be based upon the actual needs of the state and specific programs should meet those needs. Unless there is a clear plan based upon needs, there is a great danger that the program will be moulded by the availability of Federal funds regardless of whether or not the particular program for which Federal funds are available is of material importance to the state. Frequently, Federal funds in the beginning provide the entire support for a specific program and later the state is encouraged to support the program in part or in whole. Under these conditions the state would find itself supporting a number of specific programs of relatively minor importance and neglecting the prime functions of public health.

The recommended organization structure of the department would provide proper agencies and techniques for overcoming this weakness.

Public Health Education: Little coordinated work is being done in the field of public health education although individual divisions of the department do publicize particular programs. The solution to many problems of public health lies in articulate and informed public opinion. It is the duty of the department of public health to aid in developing informed public opinion by educating the public with respect to matters of public health. While the advisory council can offer valuable assistance in this respect, there is need for central coordination and direction of all public health education. The proposed plan of organization places this function in the proposed division of administration. A position should be established for a qualified public health educator to exercise this function.

* * * * *

Licensing of Maternity Hospitals and Homes: Authority to license maternity hospitals and homes at the present is vested in the children's services division of the department of social welfare. This function could more appropriately be exercised by the division of maternal and child health of the department of health. Transfer of this authority is recommended.

Centralization of Local Public Health Services:

Necessity for Centralization: Matters of public health such as communicable diseases, food control, milk supply, and nursing cannot readily be confined to a particular community. A public health problem, by its very nature, is one that threatens the health of the public at large and is not capable of abatement by individual action. All communities of the state are interdependent where public health is concerned. The most important function of the state is to see that all people receive minimum basic public health services, if not through local government then through state assistance. Centralization of local public health activities offers the only practicable means of providing minimum basic public health services to all people in the state and also offers great potential possibilities for superior local public health services because the size and population distribution in the state make it ideally suitable for centralized administration.

Existing Local Services: At the present time, each of the 39 established communities in Rhode Island has authority to provide local health services within its boundaries. The director of health has the right to approve local health officers, but this power is ineffective. Services actually provided locally range from no service at all to a full-time health department.

Public health authorities consider expenditures of $1 per capita as the amount necessary for minimum basic local health services. Expenditures of $1.50 per capita are necessary for a well rounded public health program. In the fiscal year, 1944, according to figures compiled by the Rhode Island Expenditure Council, expenditures of the city of Providence for health amounted to about $2.10 per capita. Expenditures in four communities, Newport, Pawtucket, Middletown, and Portsmouth, ranged between $.70 and $1 per capita. Six communities, West Warwick, Hopkinton, Gloucester, Little Compton, Foster, and West Greenwich expended nothing for health. The remaining municipalities expended negligible amounts.

Of the total expenditures of Rhode Island municipalities in the fiscal year 1944 for health amounting to $635,409.99, the city of Providence spent $529,944. Excluding the city of Providence the total local expenditures for health amounted to $105,465.99 or about $.22 per capita.

continued on page 316

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HEALTH DEPARTMENT STUDY

concluded from page 314

Except for a few instances, local health officers, in the main, contribute little of material value to public health either for the community or for the state, and much of the money provided for such local service is, for all practical purposes, wasted.

Such local health services as now exist are supplemented by the local district public health units of the department of health. The services now rendered in any particular community, however, differ from the services in any other community depending upon local cooperation, local demand for services, and the availability of funds.

Proposed Centralization of Local Services: Consolidation of all local health services under the direction of the director of health would afford uniform service and service of better quality than is now available, and at considerably less cost than such service could be provided independently by each Rhode Island municipality. There is, however, scant hope of affecting any reduction in the total amounts now expended by both the state and the local governments for local public health services because the present expenditures are so far below the recognized amounts required to provide minimum basic services.

Elimination of local health units may present a difficult problem because of the existence of strong feelings on matters of home rule in the state. Furthermore, in order to maintain the interest of local communities in local public health services, some provision should be made for participation by each community in the cost of the program and in the determination of policies with respect to administration of the program. Participation by local communities in the cost of the program could be done on one of two bases, as follows:

1. Each municipality could be required to contribute $1 per capita, the amount needed to provide minimum basic public health services, and the state would assume any additional cost.
2. The cost could be determined upon in advance and then split evenly between the state and the municipalities, the share of each individual municipality being apportioned according to population.

As for participation in the determination of policies, this could be accomplished through a district council consisting of one non-paid member from each community in the district. Cooperation of state and local societies in general sponsorship of centralization of local public health services might well be solicited to insure success of the program.

There is authority at present for municipalities to combine for local public health services and consolidation of local services could be accomplished right now by voluntary action under forceful leadership. There appears to be some resistance to voluntary consolidation and it is probable that compulsory consolidation would prove more effective in the long run.

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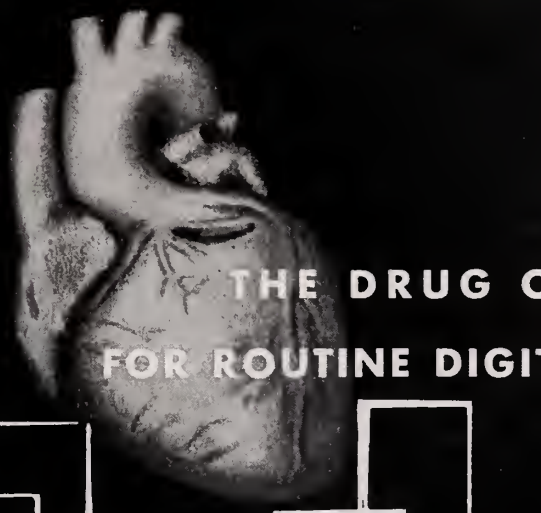
STATE AND LOCAL RELATIONSHIPS

The aspect of government which is attracting most study today is the place of each unit of government in the overall operation. Spheres of influence and activity of national, state, and local governments have of late years so overlapped that the proper distribution of functions and levels of service have completely disappeared. During the past fifteen years the increasing importance of the Federal government in the daily lives caused endless discussion. The reasons for this increasing tendency to control and regulation on the Federal level are many. The severe depression and passage of the Social Security Act placed the Federal government in a position of giving vastly expanded grants in aid for welfare and health services. The war necessitated imposing controls and regulations on activities of all kinds. It is probably that the Federal government today has the most effect of any unit of government on the average citizen.

With the increased centralization of authority in the Federal government, came a like expansion of the State government. Basically, the Federal government dealt with the State rather than the local communities, and the problems which had to be faced were usually state wide in character. That there has been a corresponding decline in local self reliance is evident. The dependence on the larger unit of government for assistance, either financial or otherwise has had the effect in many instances of removing almost entirely the local control necessary for true democratic functioning.

In Rhode Island the tendency towards centralization has been particularly noticeable. Because of its small size, the absence of county governments and its population distribution, the dominance of the state government has had full play. Many functions, normally considered as purely local in character have been taken over almost completely by the state. There have been proposals for the state to take over even more. We believe this tendency should be immediately curtailed. If not, the gradual elimination of local units of government can be foreseen.

—Abstracted from Report of the R. I. Commission to Re-Examine the Field of Governmental Relations.



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COMMENTS OF COMMISSION

The entire reports of the Griffenhagen & Associates study are filed with this report as an appendix. We believe they represent a blueprint for the guidance of the administration and the legislature in dealing not only with these departments specifically, but with the overall functions of government in general. This Commission does not agree with all the recommendations contained in these reports and so indicates in the body of this report. However, we believe that each recommendation should be carefully studied by all authorities concerned and consideration be given to the proposals made in planning for future operations. It is our opinion that the reports indicate a need for an overall reexamination of each department with a view towards better integration and administration. Such a study, carried out in the detail of these two departments would take some time and require a large staff. However, the scope of the recommendations in these reports indicates such a study would be desirable.

With regard to the specific reports, the Commission makes the following comments, indicative of its feelings on certain phases and recommendations:

We heartily endorse the proposed reorganization of the Department of Health, into seven divisions, in the interests of efficiency and economy.

The recommendation that the position of the Director of Health be a full-time career position under civil service is not in accord with our feeling that the directors of each department should serve as the Governor's cabinet and be responsible to him. We feel that the Governor should have the right to appoint and remove directors, and with this, the right to establish the working conditions and recommend the salary for the position.

With regard to the recommendation to abolish the bureau of recreational safety we are in accord. However, with the realization that this is not a function of the Health Department, goes the feeling that this activity may be a logical function of the State government, and it is our recommendation that either the activity be absorbed into the Division of Forests and Parks and their services expanded, or that the Safety Commission might take over the supervision of this program.

The recommendation that frequent and regular meetings of the staff of the director be held is an eminently sound one. We believe that if this practice were carried on in all departments there would be a better overall administration.

The recommendation for the centralization of all local public health services under the direction and control of the state director of health we disagree with for the reason enumerated in the section of this report dealing with state and local relationships.

The protection of public health is another aspect of governmental service which has tended to become centralized in the State. The expansion of the State Health department made possible by increased grants under the Social Security Act has resulted in a moving in to the local communities to provide health services.

Here again we think the program is better carried out on the local level. The State should maintain a small staff of proficient technicians to serve as advisors to the local units. It should maintain public health and research laboratories. It should provide a strong public health education program. It should encourage cooperation among the local units, but the actual work in the unit should be done and administered by local people. If there is not sufficient work in any community, a mutual banding together in a health district is feasible and desirable.

The whole tendency of allowing the State to take over services should be discontinued. If grants in aid are necessary to provide the services, the State has a precedent for making such grants. Keeping the services on the local level and keeping local interest in the services should result in better and more economical administration. The State's position of advisor, critic and consultant should aid in attaining this desirable goal.

—Abstracted from Report of the R. I. Commission to Re-Examine the Field of Governmental Operations.



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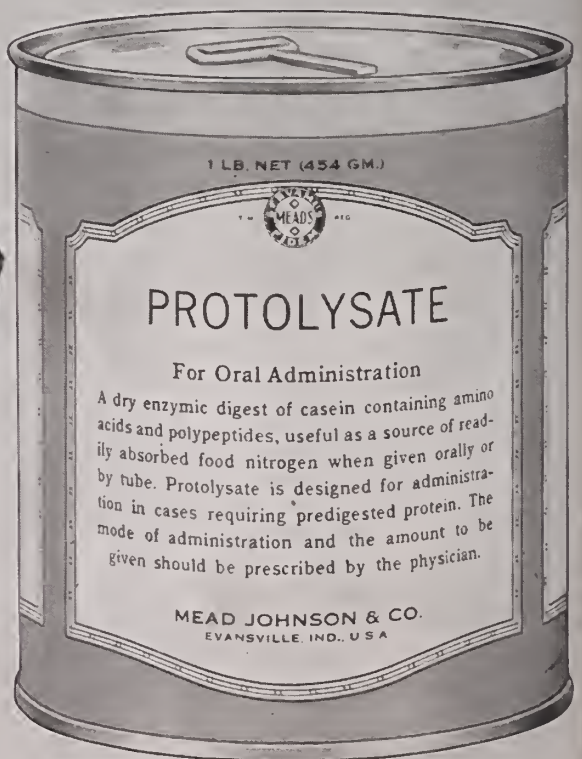
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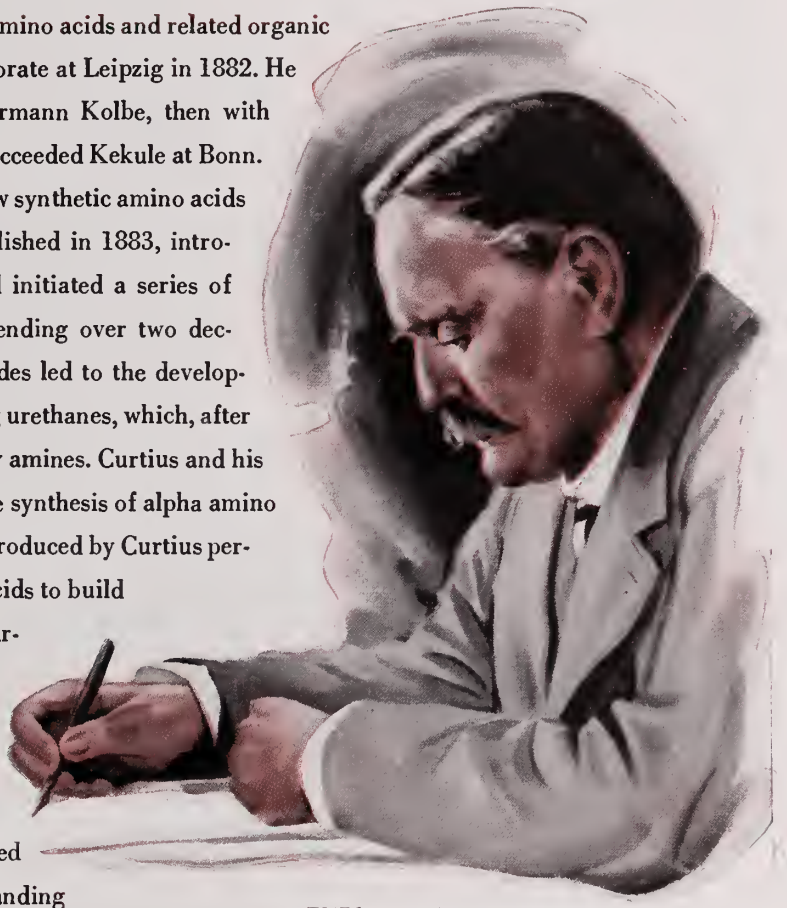
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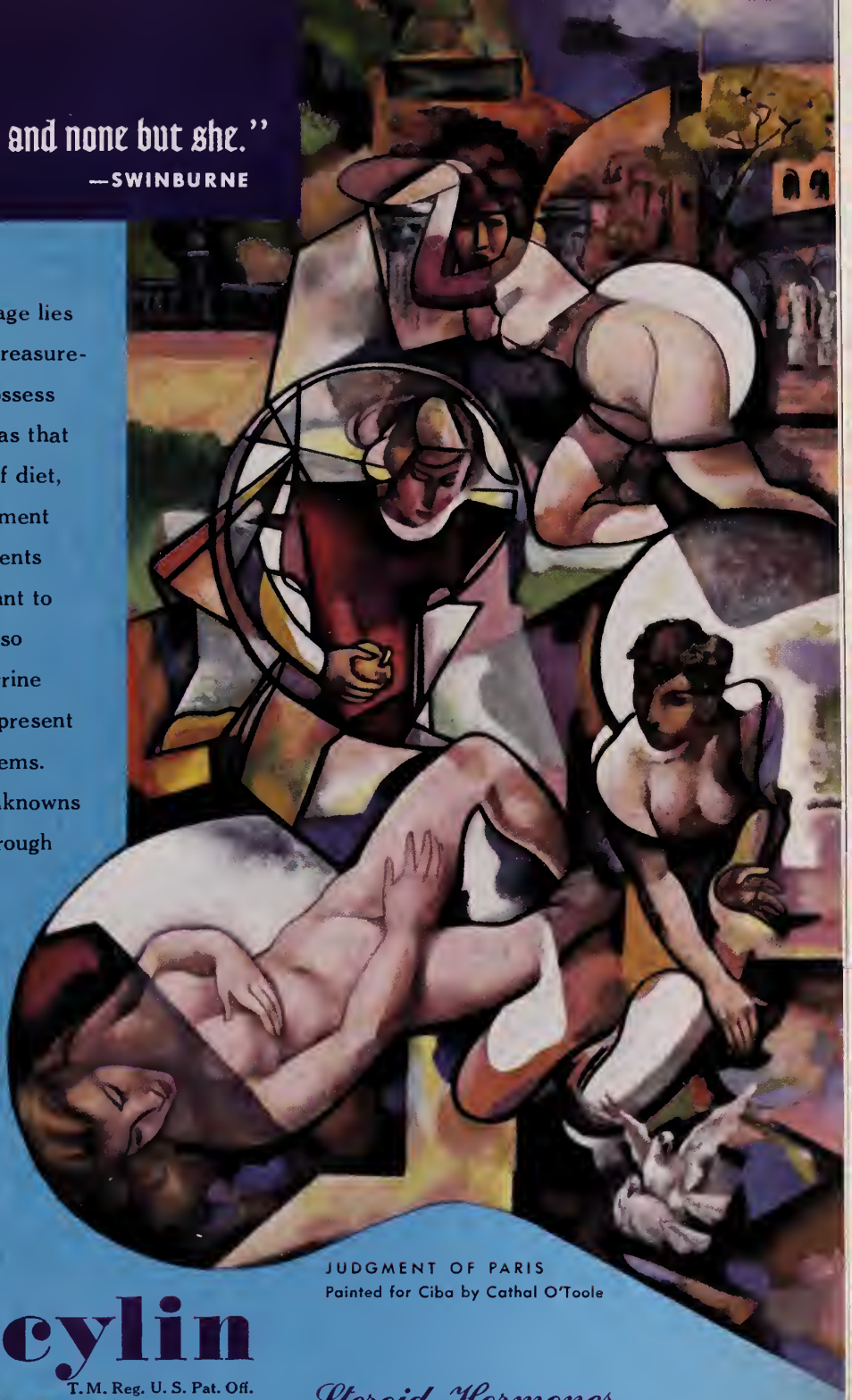
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1. Greene, R. R.: Int. Abst. Surg., 74: 595, 1942.

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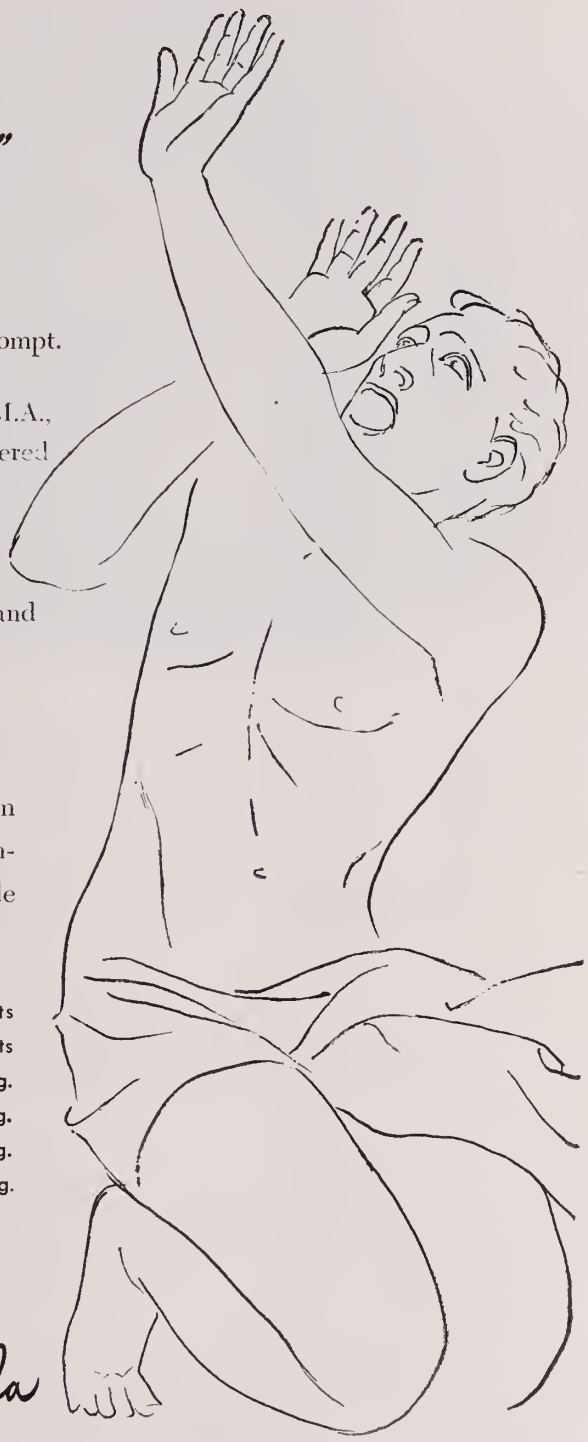
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1. Peters, J. P., and Elman, R.: J.A.M.A. 124:1206 (Apr. 22) 1944.
2. Council on Foods and Nutrition: J.A.M.A. 131:666 (June 22) 1946.

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1 National Research Council Bull. No. 109, 1943, pp. 18-21.

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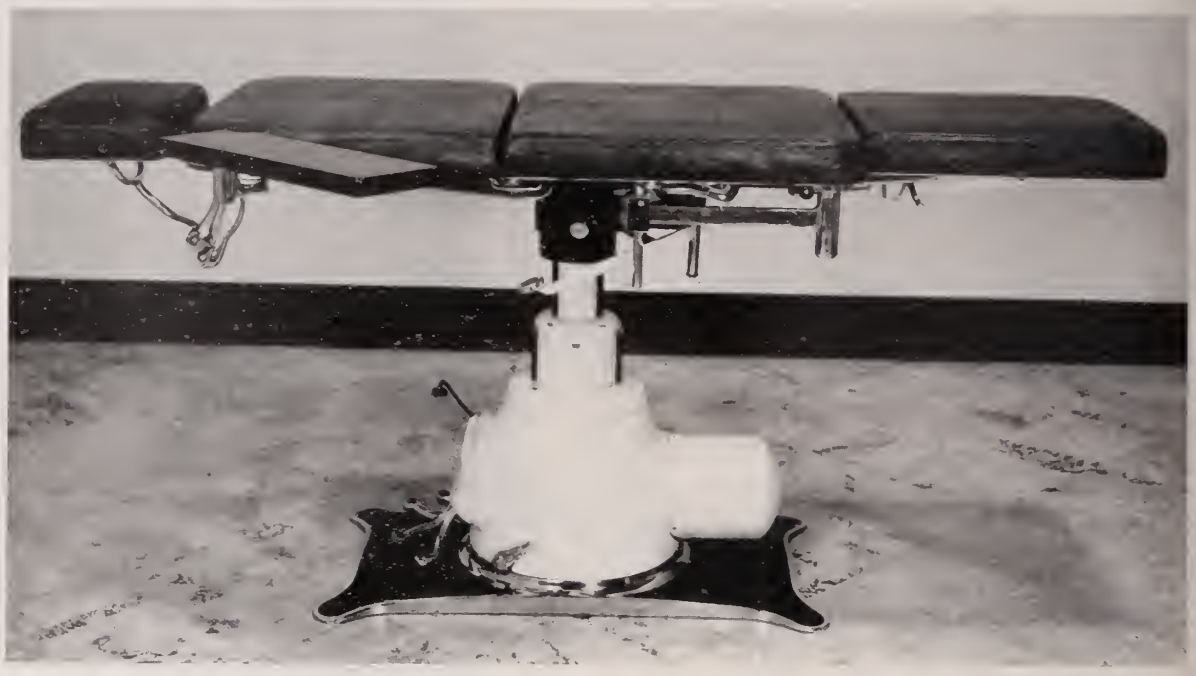
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THE ROLE OF THE GENERAL PRACTITIONER IN THE DIAGNOSIS OF PELVIC CANCER*

LEWIS C. SCHEFFEY, M.D.

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THE TITLE of my presentation means just what it says, because the general practitioner, in most instances, is the man who first sees the woman with cancer somewhere in the pelvis. We are adults, and we can speak frankly. We know that many errors are made, and for two reasons. In the first place, perhaps it is because of the reticence of many women to consult a doctor, when they notice something abnormal; secondly—and unfortunately—is the indifference with which they are too often greeted. Of course, I suppose that can apply to disease anywhere in the body, but, being a specialist who was first schooled in general practice for five years, I look back on some of my errors of omission which might have persisted, had I not entered a field so intimately connected with cancer and its management.

With respect to cancer of the pelvis in general the most common site, as everyone knows, is in the uterus. I believe that cancer of the ovary and cancer of the vulva perhaps run a rather close second, with cancer of the tube and primary cancer of the vagina—and I am using the term cancer in a broad sense—with malignancy of the tubes and vagina in last place.

What does early diagnosis, in general, depend upon? Naturally, it depends upon a careful history, but there must be, coincidentally, an evaluation of the symptoms, because the symptoms in pelvic cancer can be so insidious sometimes that it is only by a great deal of interrogation that we can find those which may be suggestive, and I think that is true of cancer in any pelvic site.

Linked with this is a knowledge of previous general and local treatment, because long-standing therapy for any condition has a distinct bearing on the diagnosis. When we hear of a patient who has been receiving prolonged local treatment to the vulva, the vagina and cervix, as with douching for a long period of time for symptomatic relief, that should distinctly disclose that something of a chronic nature is present.

The patient with so-called intestinal indigestion, who has been receiving prescriptions, we hope from the doctor, but so often from radio talks, to ease these aches and pains, should always bring to mind the possibility of hidden malignancy, such as cancer of the ovary, as well as of the intestinal tract.

Use of Endocrine Therapy

And then, in recent years—and this has become a pet hobby of mine as well as that of a good many of my colleagues, there is the long and continued use, indiscriminately advised and employed, of endocrine therapy. We see the patient who has had abnormal uterine bleeding, and we elicit a long history of injections and pills of all sorts—almost every endocrine preparation that you can think of—only too often administered for this without even a history having been taken, or a pelvic examination made.

Several years ago we presented a series of case histories at an American Medical Association meeting in Chicago, where we first cited reports in which vaginal hemorrhage of varying degree had been treated by the injection route, with no thought of examination until the finally serious hemorrhage, due to cancer, brought the patient directly to the hospital. Now, endocrine therapy is very valuable

continued on next page

*Presented at a joint meeting of the Rhode Island Medical Society and the Providence Medical Association, at Providence, February 3, 1947.

when properly employed and there is much to be said for it. It has a place, but it is a two-edged sword, and as a teaching gynecologist, I recognize, with many of my colleagues, that there is too much optimism and much light-heartedness in the use of endocrine therapy. I shall not quarrel at all with its use when properly evaluated as to indications, but what I do condemn, and what I think every one of you will agree with me in condemning, is the idea of giving a "shot" just because there is some abnormal or annoying bleeding from the genital tract that is thoughtlessly and carelessly prescribed for.

Now, when we come to the patients who have ceased menstruating, the so-called post menopausal women—and I like to say that the cessation of menstruation is only one symptom of the menopause — there, again, we are confronted with a new hazard. When I use the term "hazard" I do not mean that giving estrogenic substances actually causes the cancer that I spoke about a moment ago; I am calling attention to the fact that their use, without an internal examination, to exclude an organic cause of bleeding, creates the hazard of delayed diagnosis and proper treatment.

Now, to resume: with respect to the menopause, cessation of menstruation is only one of the symptoms. The disagreeable vasomotor disturbances that accompany it can be controlled in many instances with ordinary sedative measures and reassurance. Estrogenic therapy may be very helpful in obstinate cases. But there again, one has to be mighty careful in the dosage employed, because we have been confronted during the past few years with a wave of withdrawal bleeding from the uterus that causes us to ponder whether or not a curretage should be done at once to find out whether or not cancer is being overlooked within the body of the uterus, or whether it is simply due to estrogenic administration.

Hence, if we secure these points in the history, with regard to previous treatment, it is of decided help in evaluating the symptoms.

The Examination

Next, we come to the actual examination, and there, busy as we are, it must be thorough and painstaking, and not only confined to the pelvis, even if the symptoms apparently come from the pelvis. Dr. Pitts and I were saying earlier in the evening that so much of the teaching today is dependent upon laboratory decisions that we have replaced the eye and the finger too much, with laboratory reports, and hypodermic syringes. There is no way in which one can make an exact diagnosis of pelvic disease without an examination and we have to think of the associated parts of the body that may be involved. We know of the close association of the breast with the pelvic organs. We know that in this respect breasts are being sacrificed perhaps today that need not be, because that relationship is not thought of sufficiently long before operation is done. We know, too, speaking from the general surgeon's angle, that too often a lump in the breast is removed by the man who can remove a lump in the breast as well as any one, but who doesn't bother to have a frozen section made of that lump, and thus fails to perform the radical operation that may be indicated by that biopsy.

We must have adequate means to examine the pelvis. I mean by that a satisfactory examining table, good illumination, and certain instruments that help. Well, I suppose we would make early diagnosis of all these things—we would make an early diagnosis of pelvic malignancy, if all these things were done—if the patient came at the proper time, and if you and I examined her promptly when she came. But after all, there are a certain number of cases in which neither you nor I are going to make a diagnosis, until we have made an examination, because there are no symptoms. There are instances where the bleeding is not of sufficient character to awake the patient's fear. That is true. I can recall one case involving the uterus, in which the only symptom the patient had was a lump that appeared in the vagina and that proved to be a metastatic lesion. There was no irregular bleeding whatsoever, strange as that may seem. Therefore, we come to the supreme method of early diagnosis of cancer of the pelvic organs—the periodic examination.

I think that we are broadening our viewpoint with respect to the periodic pelvic examination. We like to include the entire body. After all, specialists shouldn't just be concerned with the field that they work in. I don't mean that they should be skilled in surgery elsewhere, but they should be at least able to examine the abdomen and breasts thoroughly enough to find some gross lesion which a periodic examination should give the opportunity to discover.

The so-called health maintenance and cancer prevention and detection clinic aims to do this. I have been in organized medicine long enough to know that there is always a certain amount of dissatisfaction by the general practitioner with a clinic of this sort. In Philadelphia we have tried to carry out a program of such clinics in cooperation with our county society. The Donner Foundation subsidized these clinics in various teaching hospitals, and then extended the program to hospitals outside the teaching orbit.

First of all, I might say that no patient is registered who is actually ill. Such are told to see their doctor. Only apparently well people are accepted. They are asked the name of their family doctor.

If the patient has none, she is given a list of doctors in the neighborhood to choose from. If she is not able to go to a private doctor, she may choose the hospital clinic that she wishes to go to, and a report of the examination with recommendations is sent to the physician concerned. No treatment is administered, not even a biopsy of the cervix, in the health maintenance clinic. In that way, we have shown the doctors that we want to work with them and help them, and the response has been gratifying.

Another movement that has been very helpful was initiated by the Obstetrical Society of Philadelphia. This was the formation of a "Committee for the Study of Pelvic Cancer," and it has been formed in cooperation with the County Medical Society and with the Department of Health of Philadelphia. We do not work with deceased patients; we go to the various hospitals for the study of material. At present our work is limited to ward patients. Soon we may even employ the committee's activity with private patients. Our scheme is to investigate the delay period in diagnosis and treatment. The program is helped financially by the American Cancer Society through its Philadelphia Division, and workers go about, study the histories, and interrogate the patients in various hospitals who are under treatment for pelvic cancer. Then, the family or referring doctor concerned is invited to come for the monthly conference, when his case is to be discussed, to present his side of the story. It is not infrequent to hear him say: "Well, I was lax in this case; I didn't know." Or, "I didn't do what I should have done. I didn't go as far as I could have." It is all done in a kindly way with a most diplomatic chairman, Dr. J. V. Howson. We then classify the case as one of patient's delay, physician's delay, or both. It parallels the work in maternal mortality that has been carried on in many communities, and it has been helpful and informative to all concerned.

Carcinoma of the Uterus

Now I wish to speak about cancer in its most common situation in the pelvis, as it concerns you and me, and that is carcinoma of the uterus. We know that carcinoma of the cervix is most frequent. Usually, it occurs on the portio of the cervix, but in a group of cases it begins inside the cervical canal. The most recent observations, I think, tend to suggest that the earliest histologic change begins with an alteration of the epithelium at that junction, between the squamous epithelium and the glandular cervical mucosa. We know that cancer of the cervix, including both histologic varieties, is most commonly seen in women who have borne children, or who have had miscarriages or infection of the cervix. The fact that it does occur in nulliparous women means that trauma is not the only cause. But, not to enter into any controversy with respect to cancer causation, we have a definite object to work with, when we think in terms of the diseased cervix. Here is a field for the employment of prophylactic principles.

To revert once more to the history, we find that the age incidence in determining the possibility of cancer of the cervix is very important. I say this because our own records, and this has been borne out by other large clinics, show an amazing figure when you consider that approximately 30 per cent of cervical carcinomas occur in women forty years of age or younger. I do not like to enlarge upon statistics, and certainly not to a general audience; but that is one figure that I mention whenever I can, for when you consider that nearly one-third of our cervical cancer patients are women in the reproductive period, it makes one realize that there is no such thing as a "cancer age."

Of course, abnormal bleeding is the main symptom that the patient notices, and she will tell you this if she has a chance. There is much less confidence to be put in the mere statement that a vaginal discharge that may be watery is present because we know there are so many causes of vaginal discharge. If blood-tinged, yes; but, it is principally when an abnormal type of bleeding occurs, whether it be in the nature of a prolonged period, or bleeding in between the periods, that only amounts to a spotting, or particularly when induced by trauma or exertion, that we must really be alert to the possibility of cancer.

From here on, I should like to show some lantern slides, and I am going to begin with some pictures of the cervix, the abnormal cervix, which tell us what we can do in a prophylactic and curative way. The first shows exposure of the vagina and cervix with a Graves' speculum. Good illumination is essential either with direct but preferably with reflected light.

Incidentally, there is an excellent manner in which to look at the cervix of the virginal woman, or even the young girl with an abnormal discharge, and that is by using the well-known Kelly cystoscope, originally popularized by Howard Kelly for air-distention examination of the bladder. Placing the patient in the knee-chest position, and using the Kelly cystoscope will aid materially in accurate observation.

The next picture is semi-diagrammatic, and shows why we have increased vaginal discharge in a cervix that has been lacerated. You first see the nulliparous or undamaged cervix, where the mucosa of the canal is protected; then there is eversion and erosion following laceration, as seen in the lower picture. It is that exposure of the cervical mucosa that gives rise to profuse and increased discharge, often containing pus because of low-

continued on next page

grade bacterial infection, more or less always present in the vaginal tract.

The next picture shows an advanced condition. Here are lacerations with everson and erosion. Hypertrophy often follows cystic degeneration with marked eversion. Here on the far right in contrast is seen a normal cervix, in which there is simply hypersecretion, with a large amount of mucus coming from the canal.

The next picture shows a cervix that has healed well; also other lacerated but healed cervices without eversion, and they are not dangerous in themselves. It is when we have eversion present, with the development of an erosion, often papillary and with hypertrophy, that we are dealing with a cervix which needs treatment, for it is at that area between the squamous epithelium and the mucosa of the cervical canal that carcinoma originates.

For the correction of minor eversion with erosion a small, nasal-type, cautery is excellent. Of course, when one is dealing with a large cervix with hypertrophy, marked eversion, and cystic degeneration, it is too much to expect a small nasal cautery to be effective. These are the cases for endothermic resection or surgical repair — a hospital procedure preferably.

The next picture, originally published by Harvey Matthews, shows what one can expect, when a cervix is properly cauterized. It takes two months and sometimes longer for a cervix to return to a normal appearance after such a cauterization.

Certain precautions must be taken in cauterizing the cervix, for unless one has made certain that acute gonorrheal infection is not present, pelvic inflammatory disease may result. It is well to be certain that the uterus is mobile, and that there is no suggestion of an adnexal mass when cauterization is contemplated.

The next picture shows some very satisfactory biopsy instruments. Whenever we are dealing with endocervicitis in which tissue breaks down easily and is friable, we should consider immediate biopsy of that area. It may be argued that the biopsy may not include an area with carcinoma in it, but when one finds a bleeding area — one that is especially friable — it is a simple matter to remove such tissue with a sharp curette or a sharp pointed pair of scissors as pictured. Personally, I am not fond of the punch, for I think that there is more trauma with that than with actual excision.

Here is a picture showing that it is a good idea, in taking a biopsy, to secure what appears to be normal tissue, too; not just a surface scraping, but enough tissue to give the pathologist the best possible chance to make an accurate decision, for in this respect his responsibility is tremendous. After removing the tissue, seal the exsised area with the cautery.

The next picture shows the way in which cervical carcinoma spreads to contiguous planes of tissue, and explains why one can feel induration in the more or less advanced cases with fixation of the parts shown. Notice above the involvement of the vaginal cervix, its extension to the vagina, and laterally into the parametrium and the regional lymph nodes.

In carcinoma of the cervical canal, we have a rapid invasion of the broad ligaments, and the same picture shows the lateral advancement with subsequent fixation. Of course, at this time it is not particularly clever to make a diagnosis of cervical carcinoma; what we aim at is early study and prompt diagnosis.

Here are a series of pictures showing early carcinomatous lesions. Of course, we have to think of certain other lesions, such as chancre and even tuberculosis, and biopsy must often be the court of last resort.

Here in contrast is a proliferative cervical carcinoma, of a marked degree. And here, in cross-section, is a small picture of advancing carcinoma of the cervix, an autopsy specimen.

I present only a few microscopic pictures. Here, for instance, is one in which the differential diagnosis has to be made from tuberculosis. Now, slides showing a well-differentiated type of lesion that approaches adult cellular characteristics (low-grade malignancy); then a bizarre one, in which we find a combination of both low and high grade types of malignancy.

The next picture shows involvement of the cervical glands and the lesion, having developed at the area previously mentioned, now appears to grow downward into the glands. This may sometimes be merely mistaken for hyperplasia, as shown in the next picture. Seen above we have an undoubted carcinoma of the cervix, and below it a carcinoma-like pattern that stimulates true cancer, but only because of the way in which the section of tissue has been cut. Some of these lesions might be regarded as "carcinoma in situ," but this is a controversial pathologic subject which I shall not attempt to discuss in this presentation. Neither shall I refer to treatment in detail except to state that irradiation is the treatment of choice in the vast majority of cases, and that surgery presents a very limited field —an exceptionally early lesion coupled with a radical and meticulous procedure performed by a skilled and experienced operator.

With respect to carcinoma of the fundus, we are dealing with a different story, for in four out of five cases it occurs in women who have stopped menstruating—a post-menopausal condition. One may look at the cervix, palpate the uterus, and find nothing abnormal; yet the bleeding is coming from inside the uterus. There is only one way to make

sure of the cause of that sort of bleeding, and that is by endometrial curettage. This slide represents a diagrammatic demonstration of the procedure, which must be thorough and cover the entire surface. The suction curett is inadequate when attempting to exclude carcinoma; if I were excluding it in my own family, it would be by thorough curettage as shown.

The next picture shows grossly the ordinary site of development of carcinoma in the upper part of the endometrial cavity. Diagnostic curettage can often be combined with preliminary therapy. I am not stressing therapy in this presentation, but in passing I might say that in carcinoma of the fundus, the opinion is gaining ground that if cancer of the fundus is irradiated before surgery is performed, the end results will be better. One can place radium in the uterine cavity at the time of curettage, and get a satisfactory report from the laboratory in four hours by means of a properly prepared section — not a frozen-section report. Then, if the lesion is benign, the radium may be removed after appropriate dosage; if malignant, a sufficiently large dosage would be given and radical surgery performed six to eight weeks thereafter. Some authorities favor preliminary irradiation with x-ray however, if the curettage shows cancer.

The next picture showing a fybromyoma with fundal carcinoma teaches a lesson. There is a "dangerous decade," from forty to fifty years of age, when bleeding from inside the uterus may be thought to be due to fibroids, because they are easily felt, and that is the time when I think that most of the failures and mistakes in the early and proper diagnosis of cancer of the body of the uterus are made. What are these mistakes? A supravaginal hysterectomy may be carried out without preliminary curettage and lo and behold, in the removed specimen will be found a cancer of the endometrium and fibroids in the wall of the uterus as well. The adnexae may have been conserved, too, and an inadequate operation has been performed! We must always think of accompanying carcinoma of the endometrium when fibromyomata are diagnosed. The association of fundal carcinoma and fibroids amounts to as much as a 50 per cent incidence in some clinics.

Here is a picture of a uterus removed, following pre-operative irradiation. Residual carcinoma, but much attenuated, is still present. A striking difference in the histologic picture is seen in the next series of pictures. They illustrate: first, a high-grade malignancy; next, an intermediate grade; finally, a low-grade malignancy, which closely simulates a marked type of hyperplasia of the endometrium.

Look closely at the next picture. This represents an early mistake of mine, that of the case of a young girl in her twenties whom we thought was an early case of fundal carcinoma because of this picture that the curettage presented. On this basis the uterus and adnexa were completely removed; there was no evidence of cancer. We would call this extreme hyperplasia in the light of today's knowledge.

You may wonder why I have said nothing thus far about diagnostic methods other than biopsy and curettage. I have purposely spoken primarily of what I think are still the safest and surest ways of diagnosing carcinoma of the uterus. There are some other objective methods to be employed when we suspect carcinoma of the cervix; painting it with Lugol's solution, the so-called Schiller test, or by inspecting it with a high-powered telescopiclens, a measure little employed today. In my opinion, and in that of a good many others, these methods are of value for one purpose only; namely, to call attention to areas that ought to be investigated further —by biopsy.

The Papanicolaou Test

With respect to the Papanicolaou test, which is being used more and more, and which is proving to be of increasing value, I have this to say. I believe it is going to be one of our best measures to detect possible carcinoma, where there is little if any visible evidence of it. In other words, it has a distinct place as a procedure in the periodic pelvic examination of women patients. I have not yet arrived at the point where, if a report were given me in which I was told that cells very suggestive of malignancy were present, that I would proceed with treatment on that basis, without verifying it by biopsy and/or by curettage. In our clinic at Jefferson, we have an excellent gynecologic endocrinologist, Dr. A. L. Rakoff, associated with us, and he has done a vast amount of work on the vaginal smear technique. Our laboratory of cytology has been responsible for reports on all of the smears taken in the cancer prevention clinics in Philadelphia. To interpret them properly requires an expert knowledge of the morphology of the vagina, the cyclic changes that occur therein, and thorough and lengthy experience is essential in evaluating the abnormal cells that are found in suspicious cases.

The first picture that I am going to show you is a normal one from a patient with good ovarian function, showing vaginal epithelial cells that are well cornified. Secondly, a smear from a menopausal patient, showing small, basophilic cells, and indicating marked estrogen deficiency, as stained by Shorr's method. Here is one in which we see normal endometrial cells. Next, a slide showing normal cervical cells and leukocytes.

Thus far, we have shown you typical cells, indicative of normal cytology at different phases. The

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THE TREATMENT OF SMALL BOWEL OBSTRUCTION*

ROBERT R. BALDRIDGE, M.D.

The Author. *Robert R. Baldridge, M.D., of Providence. Surgeon, Rhode Island Hospital.*

BENNETT[5] has said that in the earlier days the mortality of intestinal obstruction was about 70 per cent. Jeff Miller,[19] in 1929, reported a mortality rate of 61 per cent. In 1942 Dennis and Brown[11] asserted that the average mortality rate in the best clinics was about 18-20 per cent. Eliason[12] in 1947 reported that 17 per cent of all deaths at the Philadelphia General Hospital over a 10 year period were due to intestinal obstruction. I find that during the last four years, the mortality rate at the Rhode Island Hospital has been 22 per cent!

Why do these people die? What are the pathologic effects of obstruction? Effective treatment in this, as in any surgical disease, is impossible without an understanding of the underlying pathology and pathologic physiology.

Death from intestinal obstruction occurs either from infection due to perforation and peritonitis, or from shock, or from a combination of these two.

The effects of perforation, and the necessity for early operation in cases of strangulated obstruction need only be mentioned. There is general agreement that if the diagnosis of strangulation is suspected, early operation is imperative if peritonitis is to be avoided. It may not be so generally recognized, however, that the results of so-called SIMPLE obstruction may be just as lethal. It has only been in recent years that an understanding of the effects of intestinal DISTENTION[15, 26-29] have been emphasized. These effects are both mechanical and metabolic, and are extremely profound.

Distension of the intestine, which is due to a combination of accumulated fluid and swallowed air,[27] interferes mechanically with bowel function. Not only is there an increase in the process of secretion, but a marked reduction in the power of absorption. When it is remembered that the small intestine secrets and reabsorbs about 8000 cubic centimeters of fluid in 24 hours, and that a large amount of this total may be lost to the circulation by vomiting or stasis in distended loops, one of the first calamities of obstruction may be appreciated.

Distension has also been shown to decrease circulation in the capillaries of the bowel wall.[17] This decrease is proportional to the amount of distension, and the heighth of the diastolic and systolic blood pressures. When tension within the bowel lumen exceeds the diastolic pressure, serious interference with circulation occurs, and gangrene is inevitable should intraluminary pressures exceed the systolic blood pressure. Local anoxia of varying degrees is produced in all cases of obstruction, the capillaries become permeable, and variable amounts of blood, plasma, or both may be lost into the bowel wall, its lumen, and into the peritoneal cavity. As much as 45 per cent or more of the total circulating plasma may thus be lost, and the patient literally bleed to death into his own tissues, all without perforation or peritonitis![1,2,4,13,14,24]

It should be noted that this loss of plasma and/or blood is not necessarily portrayed in the hematocrit readings or in blood plasma percentages since, due to dehydration, the plasma percentages may be normal although the total circulating blood plasma is greatly reduced.[1,2,4,14,21]

In addition to the mechanical effects of distension, equally profound and complementary disturbances of a metabolic nature occur. The loss of large amounts of fluid already described results in rapid dehydration and an equally severe loss of electrolytes.[1,2,9,13,14,17,26]. Should obstruction occur high in the small intestine, there is a profound loss of chloride and excess sodium is excreted through the kidneys. In obstructions of the lower small intestine there is loss of both sodium and chloride, but to a lesser degree. Loss of water and electrolytes dominate the picture in high obstructions, — distension and its consequences in the low.[2,9]

Given dehydration, hypochloremia, diminished circulating base, depleted plasma, and possibly anemia, the stage is set for shock. Azotemia develops, cardiac output diminishes, vaso-spastic defense mechanisms fail, the blood pressure falls, generalized capillary permeability and anoxemia develope[21] and the patient *DIES*, all without, in many cases, perforation or peritonitis!

Except in the case of perforation, infection plays no essential role in the above train of events and it

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should be remembered that the central and initiating factor has been bowel distension and dysfunction.

From the above brief review, it seems readily apparent that the successful treatment of intestinal obstruction implies early recognition and early operation, before the complications resulting from infection and/or distension will have occurred. Statistical studies by McKittrick,[18], Eliason[12] and others amply support this view.

It seems equally obvious that early surgery in cases which have already developed the profound disturbances above described would, in most cases, be worse than useless.[22] To operate on the distended shocked patient is to invite the calamity we are trying to avoid. The immediate indication in such cases is for vigorous medical treatment directed toward the relief of distension and the resulting deficiencies in fluids, electrolytes and protein. These measures may be briefly summarized as follows:—

1. Decompression of the distended bowel with either the Miller-Abbott or Harris tube, and Wangensteen suction.[3,6,8,16,20,22,26]

2. Replacement of fluids and electrolytes as rapidly as possible. Coller[9] recommended one-half gram of sodium chloride per kilogram for each 100 points the blood level of chloride was below normal.

3. Transfusions of blood and plasma, based upon estimated losses.

4. Intravenous injections of such protein foods as amigen and parenamine. Large amounts of the vitamin B complex and of cevitamic acid should likewise be given. It is to be remembered that these patients are in a state of starvation.[1]

5. Such anti-biotics as sulfathalidine, sulfasuxidine, penicillin and streptomycin may be of value, especially in cases where perforation is imminent. It has been shown experimentally that the lives of dogs suffering from strangulating obstruction may frequently be prolonged or spared if the anti-biotics are used in adequate doses.[7,23]

6. Oxygen therapy may be of value. We do not consider the prolonged use of 95 per cent oxygen, as recommended by Fine,[15] to be necessary. Intubation for the treatment of distension is much more effective. On the other hand, the use of oxygen may be valuable as a supportive measure, especially if there are any cardiac or pulmonary complications. It has been shown experimentally that distension produces reflex pulmonary, liver, and renal disturbances which are mediated through the splanchnic nerves. The effects are prevented by splanchnic nerve section and are somewhat diminished by the use of oxygen.[10,25]

Conclusions

If any general rules may be formulated for the treatment of obstruction of the small intestine, I would suggest the following:—

1. Operate early on all early cases, but especially on all early cases if strangulation or so-called "closed-loop" obstruction is suspected. The only exception to this rule in my opinion should be in obstruction which follows recent laparotomy. Such cases usually respond to intubation and medical treatment.

2. Operate on late cases only after adequate medical treatment has been instituted. It is true that some of these late cases may be about to perforate and that perforation may occur during the period of medical treatment. This risk must be taken in the interest of those late cases of non-strangulation "simple" obstruction whose lives would be forfeit by surgery before adequate resuscitative measures had been carried out.

3. Suction intubation and surgery are complementary methods of decompression, and may be applied simultaneously.

4. Patients must be evaluated as individuals, not groups, and the type of treatment, whether medical or surgical, based upon an understanding of the extent and degree of the pathologic factors involved at any given time.

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ROLE OF GENERAL PRACTITIONER IN PELVIC CANCER DIAGNOSIS

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next picture is the one which is well recognized by workers as showing "tadpole" cells, often seen in well-differentiated cervical carcinoma. That has the typical pattern familiar to many of you.

Next we see that in addition to this very typical cell, there are those of other morphology, not significant unless the nucleus also is abnormal. In other words, the cell shown on this slide, appearing as a "tadpole" cell, does not have an abnormal nucleus. In the less differentiated carcinomas, embryonic cells are found too. In this one, which is from an adenocarcinoma of the cervix, the cells are smaller and particularly bizarre.

Next, is one in which a carcinoma of the uterus was found and it is very characteristic.

Here is one from a case of endometrial carcinoma, with large clumps of cells present. The individual cells in carcinoma of the endometrium show marked variation in the size of the cell and in the size of the nucleus. They are less specific in diagnosis perhaps than in the case of cervical carcinoma.

I am frank to say that the Papanicolon smear technic in the diagnosis of uterine cancer is a study in itself. I have the opportunity to look at these slides and I think I am learning something about them, but I must depend upon an experienced examiner, such as Dr. Rakoff, for accurate information.

We have made a rather voluminous study of this problem. We have taken 500 consecutive cases, from the gynecological service in the past year and a half, in which we have taken only one vaginal smear from the posterior fornix and one from the cervix and the slide has been identified by number; then the pathologic report of that case has been studied and similarly numbered. Those working on the cystologic slides do not know what the pathologist's findings are, and vica versa. On the basis of this we have investigated and compared to date 418 cases without either worker knowing about the other's findings. We have had 59 patients with cancer of the uterus. Of those 59, there were 41 correct diagnosis, as proven pathologically, or 70 per cent. The percentage of error, or false negatives, was 28 per cent. In other words, 17 cases of cancer were not indicated by the Papanicolaou test. Of the patients who did not have cancer—359—we had 4 false positives, a trifle over 1 per cent.

What can one conclude from this? We purposely didn't repeat any of these smears on the same patient, because we wanted to find out what would be the advantage of taking a single routine slide in any clinic anywhere, and evaluating the diagnosis on that basis. By such a procedure, the percentage of error approximates 30 per cent of false negatives.

Pursuing the work further, we now are taking repeated slides from the cervix and from the posterior vaginal fornix for comparison. Thus far, strange as it may seem, correctness has been evidenced more by the smears from the posterior vaginal fornix. We also feel that repeated smears should be taken in the suspected case from time to time.

I should like to reiterate what I said. I think that this test offers us a great deal in periodic examinations where we are studying women with no definite symptoms or signs of carcinoma of the uterus. I think that we have an excellent opportunity to do a great deal of prophylactic work in the early detection and prompt treatment of cancer. However, I am not nearly as confident about the accuracy of the test as Dr. Joe Meigs is; I would not be willing to advise and plan irradiation or surgical treatment except by confirmation through biopsy and/or curettage.

LYMPHATIC SPREAD OF CARCINOMA AND ITS MANAGEMENT*

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THE PROPENSITY to form lymph node metastases is a common characteristic of many types of malignant neoplasm. The mechanism by which the metastases develop is fairly well understood. As a cancer grows locally, cancer cells invade the intercellular tissue spaces where the lymphatic channels take their origin. Single living cells, or small groups of cells become detached from the main mass of cancer and are carried passively by the lymph to the nearest lymph node in the course of the lymphatic vessel. Here the cells are caught in the mesh of the reticulum and become implanted as a cancerous metastasis. The growth of the implant in the node eventually blocks the lymphatic drainage by way of the node. The lymph draining from the original focus must then proceed by way of collateral channels, with the result that other nodes may become involved by a similar mechanism. More centrally situated nodes may be invaded secondarily by groups of cells separating from the primary metastasis, again following the lymph stream to the next higher node.

Thus the usual mechanism of metastasis is by lymph stream embolus. In late stages, when the lymphatic drainage from the primary locus is greatly slowed and impaired, and the lymphatic channels are greatly dilated, propagating thrombi of cancer cells may develop. However, such dispersion by propagating thrombus is not the usual method of metastasis formation, and is restricted to a few highly malignant tumors, and to the late stages of others.

Certain factors seem to influence the occurrence of lymph node metastases, among which the type of malignant growth seems to be most important. For instance, lymph node metastasis is unknown or rare in basal cell carcinoma of the skin, or in osteogenic sarcoma; while it is very common in malignant melanoma.

*Presented at a meeting of the Providence Medical Association at Providence, April 7, 1947.

In addition to the type of neoplasm, the grade of malignancy, that is the characteristic recognized histologically as evidence of rapid and invasive growth, is significant in relation to node metastases. Thus a carcinoma of the lip or high grade of malignancy has a great likelihood of forming metastases, while the low grade lesions only rarely spread to the nodes.

The location of a carcinoma in relation to lymphatics is also significant. An explanation of the rarity of node metastases from osteogenic sarcoma may lie in the relatively poor lymphatic drainage of bone, in contrast to the rich lymphatic drainage of the tonsillar area, where node metastases are very common. Similarly, the location of a tumor in an area subject to motion because of underlying muscles predisposes to metastasis formation. Thus carcinomas of the soft palate, tongue and floor of the mouth metastasize freely and early, while those of the gingiva and hard palate form metastases less freely, and later.

A corollary consideration should be emphasized; namely that undue or excessive manipulation of a cancer may provoke metastasis.

Study of the incidence of node metastases correlated with the characteristics of the primary carcinoma demonstrates that they are more likely to be associated with lesions of large size and long duration. They are also more likely to develop when a previous unsuccessful attempt has been made to extirpate the primary carcinoma.

With these factors in mind we can proceed to consider the questions of whether and when to carry out dissection of the regional lymph nodes.

Dissection should be carried out when regional node metastases are present, or when there is considerable likelihood of involvement. The clinical recognition of early metastasis is so fallible that it is unwarranted to assume freedom from metastasis simply because no enlarged nodes can be felt. Indeed, the clinical interpretation of lymph nodes may be in error in 30 per cent of cases. In case of indecision as to whether dissection is necessary or not, it may be justifiable to defer operation until definite metastases appear, provided that the patient may be trusted to report frequently for a thorough search for the nodes. In adopting a policy

continued on next page

of watchful waiting the operative risk must be balanced against the danger to the patient of a dissection deferred too long.

Lymph node dissections constitute an integral part of the operations for carcinoma of the breast, stomach, colon, rectum, and the Wertheim operation for carcinoma of the cervix. These operations include the intervening lymphatic vessels along with the regional nodes. Similar radical one stage procedures may be employed for carcinoma of the salivary glands and thyroid, and for certain malignant melanomas of the skin situated adjacent to the regional nodes. Results of radical surgery in such cases when nodes are involved are shown in Table I.

Table I.

CURES IN CARCINOMA WITH NODE METASTASES

One Stage Operations

Primary Tumor	*Per Cent*
Breast	33
Stomach	15–20
Colon	30–45
Rectum	20–33
Cervix	20

In dealing with carcinomas of the skin, mouth, and genitalia, dissection should be carried out after the primary focus of disease has been eradicated and healing has taken place. It was pointed out above that in certain cases it may be legitimate to defer dissection until metastases are definitely present. In others, especially when characteristics of the primary carcinoma argue for the great likelihood of metastasis, dissection should be performed prophylactically, even when metastases are not obvious. Results in cases with node metastases in which these dissections have been performed are shown in Table II. Cases in which there was failure to control the primary carcinoma have been omitted.

Table II.

CURES IN CARCINOMA WITH NODE METASTASES

Two Stage Operations

Primary Tumor	*Per Cent*
Skin	33
Melanoma	18
Lip	58
Tongue	43
Mouth (Other Parts)	42
Vulva	35
Scrotum	20
Penis	52

Recently Nathanson has developed a modification of Taussig's operation of iliac lymphadenectomy to dissect the regional lymph nodes following radiation treatment of carcinoma of the cervix. While it is premature to attempt to assess the results of this procedure in terms of cures, it is interesting to note that residual carcinoma is found in many of the nodes removed in this dissection; and it is to be hoped that some of these patients will be cured as a result of operation.

SUMMARY: Lymph node metastasis as a result of lymphatic embolus, is a common characteristic of many types of malignant neoplasm. Its occurrence is related to the nature and grade of malignancy of the primary neoplasm, the location in relation to muscles and lymphatics, and the size and duration of the primary carcinoma.

Dissection of the regional lymph node drainage area, either as part of the primary operation, or as a separate operation, may effect a cure in a considerable number of patients even when metastases are present. Prophylactic dissections should be performed when the primary carcinoma is of a character likely to be associated with node metastases.

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GALLBLADDER PERFORATION*

— *An Unusual Case with Laceration of the Liver and Hemoperitoneum* —

ARTHUR E. HARDY, M.D., F.A.C.S. and PHILIP J. SPELMAN, M.D.

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HEMOPERITONEUM from nontraumatic rupture of the gallbladder occurs infrequently. Mailer[1] reviewed five cases of massive intraperitoneal hemorrhage from perforated gallbladder, which had been reported between 1858 and 1939, and reported an additional case of his own. In one of the cases, hemorrhage occured from the cystic artery which was torn when the gallbladder ruptured at its neck. In the others, bleeding was from the torn gallbladder substance or from the vessels in its enveloping peritoneum. Two of the six cases which he discussed recovered following operation.

Sanders[2] reported a case in which "abdominal exploration revealed large old blood clots under the liver margin about the gallbladder. The latter organ was . . . filled with bloody fluid, and its wall was gangrenous. In its fundus was a perforation from which the blood had escaped into the peritoneal cavity." Vest[3] reported a case in which at operation an unspecified amount of blood and necrotic material was discharged on opening the peritoneal cavity; the cause was not apparent until postmortem examination revealed two large perforations of the gallbladder. Wyse[4] observed at autopsy a gallbladder perforation with over 700 c.c. of blood and clot within the peritoneal cavity.

Gross bleeding from the liver itself resulting from nontraumatic gallbladder perforation has not previously been reported. Perforation of the gallbladder into the liver, however, is not so uncommon. Of forty-six cases of gallbladder perforation reported by Sanders[2], nineteen entered the liver, as did two of Stout and Hibbard's[5] six cases of perforation and one of Cowley and Harkins'[6] series of twenty-five. In none of these was hemoperitoneum a feature.

Because of the rarity of massive intraperitoneal hemorrhage resulting from gallbladder perforation and because in none of such cases reported has the liver substance been the source of the hemoperitoneum, the following case treated at this hospital is considered to be worth reporting.

Case Report

A 52-year old Italian housewife entered the Rhode Island Hospital October 4, 1946 at 12:20 P. M. Two and one-half days before admission she was awakened from her night's sleep by cramp-like pain in the right upper quadrant of the abdomen, radiating to the right shoulder. The pain persisted with increasing severity. Except for one episode of vomiting of oral medication prescribed by her physician, she retained fluids taken by mouth. She denied jaundice, acholic stools, dark urine and intolerance of fatty foods. There was no history of trauma to the abdomen.

She had had an attack of pain seven years previously, similar to the present episode in nature but less severe, which subsided under treatment at home.

Physical examination on admission showed a short, obese, middle-aged woman complaining of severe pain in the right upper quadrant of the abdomen. Rectal temperature was 101.4° F. Pulse was 120 per minute and blood pressure 94/60. Respirations were 36 per minute and shallow. There was no icterus. The heart and lungs were normal. There was marked direct tenderness and moderate muscular spasm throughout the right hypochondrium. A fluid wave was not demonstrable.

Chest x-ray showed no free gas under the diaphragm. There were several dense streaks in the lower right lung field which were considered to represent small areas of atelectasis. X-ray of the abdomen (patient upright) showed diffuse haziness throughout the lower abdomen suggestive of fluid. No opaque shadows were seen.

Hemoglobin was 6.9 grams per cent. Red blood cells were 2,860,000 and white blood cells 19,600 per cubic millimeter with 90% polymorphonuclear neutrophils. Urinalysis: Albumen 2+, glucose negative; microscopically there were 8 to 10 white blood cells per high power field. Prothrombin activity was 55% of normal.

She was prepared for operation with 1000 c.c. 5% glucose in distilled water by vein. 4.8 mgm. of synthetic vitamin-K and 50,000 Oxford units of

continued on next page

*From the Second Surgical Service, Rhode Island Hospital, Providence. The authors thank Emery M. Porter, M.D., Surgeon-in-Chief, for permission to publish this report.

sodium penicillin were given intramuscularly.

Five and one-half hours after admission laparotomy was performed under cyclopropane-oxygen anesthesia by the endotracheal method, supplemented by "Intocostrin". A right subcostal incision was made. As the peritoneum was opened a large amount of free blood, stained with bile, welled into the wound. There were many free blood clots up to three inches in diameter. The total volume of fluid blood and clot amounted to approximately 1300 c.c.

There was a perforation in the distal third of the gallbladder extending into the gallbladder bed. In the liver, contiguous with the perforation, there was a laceration 2.5 cm. in depth, extending through the liver margin. The raw surfaces of the laceration were bleeding freely. A single oval calculus, measuring 2.5 cm. in its greatest diameter, was fixed in the ampulla of the gallbladder. This was milked free and removed. The gallbladder was removed from below upward. The common bile duct was normal to palpation.

Bleeding from the lacerated portion of the liver was controlled by warm saline packs followed by "Oxycel" gauze. A rubber tissue drain was led out through the wound from Morrison's Pouch.

The wound was closed with stainless steel wire sutures and Michel skin clips.

Two hundred c.c. of physiologic saline solution and five hundred c.c. of citrated whole blood were given intravenously during the operation. The patient withstood the procedure well.

Her postoperative course was complicated by a mild, lower respiratory infection arising in a transient, partial atelectasis of the lower lobe of the right lung. She was afebrile by the seventh postoperative day and ambulatory at the time of her discharge on the thirteenth postoperative day.

Pathologic diagnosis was chronic cholecystitis, cholelithiasis, and acute, ulcerative cholecystitis with gangrene.

Comment

Neither the pathogenesis of rupture of the gallbladder in acute and chronic disease nor the relation of perforation to calculi is the topic of this report. Vest[3] and Cowley and Harkins[6] have published reveiws of the subject. Mailer[1] has stressed the importance of circulatory disturbance due to stones in causing perforation, even in the absence of histologic evidence of acute inflammation.

In the present case several of the conditions which predispose to perforation existed. There was a large, impacted ampullary calculus strategically located to jeopardize the circulation of the gallbladder at its neck and to obstruct the outlet. Histologically there were acute inflammation, ulceration, and, in the region of the perforation, gangrene of the gallbladder wall.

Fortuitous selection of the gallbladder bed as the site for forcible rupture produced the laceration in the liver observed at operation.

Summary

A case has been reported of perforation of the gallbladder with hemoperitoneum from a lacerated liver, without external trauma.

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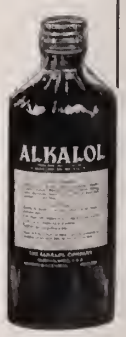
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A NEW TUBERCULOSIS CONTROL TECHNIQUE

On April 7th last, a new activity was inaugurated at the Rhode Island Hospital, in the dedication of a photofluorographic unit. This is to be used for chest screening of large numbers of hospital and out-patient admissions as well as employees.

Formal dedicatory ceremonies were attended by the members of the hospital administration, the president and members of the Board of Trustees, representatives of the State and City Health departments, and officials of the Rhode Island Tuberculosis Association. Various members of the nursing and medical staffs were also present. Those who took part in the simple ceremonies were the first to be actually examined by the machine.

The unit itself is fully automatic and capable of taking care of 100 to 150 patients per hour depending upon the clerical organization. The films are developed in long 100-foot rolls which contain up to 350 exposures per roll. The later reading of the films is done very rapidly and conveniently by means of a new special type of viewing and magnifying device. The examination with the present types of screening apparatus is much simpler than before and it is not necessary to remove all the clothing. Only the outer clothing is taken off, plus any unusual metallic objects in the pockets.

The unit is located close to the entrance of the Potter Building for Children, at a point where all admissions automatically pass. The location is designed to facilitate examination of all admitted cases able to walk. Eventually out-patients and ambulant accident cases will also pass through this department. It is also planned to have periodic examinations of all employees. The nurses will be examined every three months, the interns every six months, and other members of the medical staff and other employees at least annually. Later plans will probably include pre-discharge examinations of all patients who were too sick on entrance to pass through this department. Eventually it is possible that hospital visitors will be included in the groups to be examined.

This type of activity in general hospitals is somewhat new in our community, but is in step with growing practice in the development of the general campaign against pulmonary tuberculosis.

The entire tuberculosis problem has been under consistent attack in this country for approximately forty years. In the early days, the campaign was directed toward eradication of tuberculosis from herds of cattle with the eventual production of tuberculosis-free milk and tuberculosis-free meat. This has been aided by the campaign for more general pasteurization of commercial milk. Later efforts were concentrated at the level of case-finding among contact cases by means of tuberculin testing, careful physical examination, and in later

continued on next page

years routine x-ray study. These older methods proved to be too cumbersome and too expensive for a really wide-spread and comprehensive universal campaign against tuberculosis. The discovery of new types of photofluorographic equipment furnished a comparatively inexpensive x-ray screening method that could be applied easily to large units of people. The examinations were first applied to groups of school children, later to industrial groups, and finally to other organized groups such as labor unions.

The concept of utilizing this important method in general hospitals is a matter that has been developed comparatively recently. The total number of hospital admissions throughout the country annually, and the number of out-patient admissions in these hospitals, total up to many millions of individuals. This furnishes a tremendous unorganized group of people who otherwise would never be touched by the numerous public health programs directed toward the other organized groups. It must be understood, of course, that the use of this unit does not constitute a complete x-ray examination of the chest. It is merely designed to afford a very rapid method of screening out individuals with essentially normal chests from those showing signs of recent or old tuberculosis.

In addition, cases showing other gross non-tuberculous lung pathology or gross pathology of the heart and great blood vessels will also be easily and quickly detected. In these investigations, it is always the intention that cases showing abnormalities are to be sent to their physicians for further investigation which may include more complete x-ray study.

With regard to general hospitals themselves, a very important problem in recent years has been the development of tuberculosis among medical students, nurses, interns and non-medical personnel. The use of this unit will make it a comparatively simple matter to examine all such personnel at frequent enough intervals to detect the very early incidence of tuberculous re-infection.

Hospital admissions showing tuberculosis will eventually of course, have to be separated from other patients. This is a matter which must be gradually worked out in all the general hospitals. It is probably true that the more wide-spread extension of these units in general hospitals, such as the Rhode Island Hospital, will start a chain of complications requiring new efforts in the war against tuberculosis. At present, our sanatoriums treat mostly cases which are moderately or far advanced. In the future it will be necessary to devise institutions or other means of segregation and treatment which will take care of the large numbers of very early cases of pulmonary tuberculosis. These cases will be in the groups where the chances for rapid and complete cure are very encouraging.

The Rhode Island Hospital is to be congratulated upon the institution of this new facility, which was acquired largely through the co-operation of the Rhode Island Tuberculosis Association. This is merely a beginning in a new type of campaign against tuberculosis, which will result in greater good than ever before, but at the same time, will entail more responsibilities and more complications.

DR. EDMUND D. CHESEBRO

Any man who was born in the year that the Emancipation Proclamation went into effect, Grant captured Vicksburg and Meade defeated Lee at the Battle of Gettysburg, is entitled to take it easy now, but Dr. Edmund D. Chesebro, who started life in that year of 1863, celebrated his 84th birthday last month and is still making many house calls in the forenoon, acting as Chief Medical Examiner of the Puritan Life Insurance Company and keeping office hours on five afternoons and evenings a week.

He was born in Stonington, Connecticut, in those days a famous seaport and home of many a renowned deep sea captain. He graduated from Brown in 1887, from Columbia Medical School in 1890, and that summer started practice on Hawthorne Street in this city. There used to be a saying, "Old Dr. Blank, forty years on the same corner and then they moved the corner." After fifty-seven years they haven't moved the corner from Dr. Chesebro. He is still practicing on Hawthorne Street.

He began service in the out-patient department of the Rhode Island Hospital in 1891, transferred to surgical, and later back to medical, and beginning in 1902 was visiting physician on the house service for nineteen years.

In 1909 he was President of the Providence Medical Association and in 1916 was President of the Rhode Island Medical Society. Many of us will remember the delightful party he gave at the Rhode Island Country Club to celebrate his completion of fifty years in practice.

If there is anybody specializing in Geriatrics in this neighborhood we doubt that he will get E. D. Chesebro as a patient. The doctor admits that he doesn't make as many calls as, for instance, in the influenza epidemic at the end of World War I when he made sixty house calls in a day, but he shows no evidence of finding it hard to carry on a busy practice.

Congratulations to our lively young fellow practitioner.

THE DANGER OF RECIPROCITY

In recent years there has been agitation for uniform licensure regulations in the States for those seeking to practice the healing art. Many states

have for years allowed licensure by reciprocity, and have so provided in their statutes. Others have granted licensure through endorsement by board regulations whereby the applicant is carefully checked to insure that his educational and professional training is equal or comparable to that required of those licensed by written and oral tests.

The great danger inherent in the procedure of reciprocity has been thrown into sharp relief in our neighboring state of Connecticut within the past three months. There the statutes provide that a person licensed to practice naturopathy in another state may be given a license in Connecticut without taking the healing arts examination. As a result, in the past 24 years only four naturopaths of the state have obtained certificates of approval by taking written examinations of the State Board of Naturopathic Examiners, whereas within the past three years thirty-six men have been qualified on the basis of reciprocity and length of previous practice.

This issue is highlighted further by reason of the fact that the so-called practice of naturopathy has never been substantiated on any sound basis. Two years ago the RHODE ISLAND MEDICAL JOURNAL printed an article by the executive secretary of our Society on naturopathic legislation and education. The conclusions as the result of that study were that no school confines its teaching to naturopathy, and for the most part the institutions upon which a report was made were promotional enterprises dispensing diplomas to anyone who will pay the tuition fee. That report was widely circulated throughout the country and has been cited in assembly hearings in many states where naturopathic legislation was proposed.

In January of this year the general assembly of Tennessee, where naturopathy has flourished with vigor for years, took the most drastic action yet by repealing in its entirety the statute allowing the practice of naturopathy in that state. At the present time investigations and prosecutions are being pursued by the State against naturopaths.

This action by Tennessee is certain to have its repercussions. Certainly it must be a cause for concern in Connecticut, or any other state where reciprocity procedures have opened the door otherwise unlatched only for those qualifying by examinations. Just how dangerous the problem can be was well illustrated in the hearings before a Connecticut legislative committee when the chairman of the State Board of Healing Arts cited two applicants for licenses who had failed Connecticut's healing arts examinations three times, with average grades of 27 and 45 per cent, and then secured licenses in another state, returning to Connecticut to practice under reciprocity licensure.

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DIVISION OF MEDICAL SCIENCES

COMMITTEE ON DRUG ADDICTION

April 15, 1947

Dr. Peter Pineo Chase, Editor
Rhode Island Medical Journal
106 Francis Street
Providence, Rhode Island

Dear Dr. Chase:

During the past ten years the Drug Addiction Committee of The National Research Council has sponsored the investigation in the laboratory and clinically of a new morphine derivative, Metopon hydrochloride (methyldihydromorphinone hydrochloride). This study has demonstrated that Metopon possesses certain outstanding advantages which could make it the drug of choice for the treatment of the pain of cancer, especially in the home care of terminal cases, and for that purpose the Committee has recommended its manufacture and limited marketing. The contemplated plan of limited and controlled availability of the drug is based upon its narcotic character, its somewhat limited supply on account of manufacturing difficulties, and its advantageous applicablity only to the type of case indicated. The manufacturers, Mallinckrodt Chemical Works, Merck & Co., Inc., and New York Quinine & Chemical Works, Inc., who are the firms licensed to manufacture morphine, and the distributing pharmaceutical houses, Sharp and Dohme, Inc., and Parke, Davis & Co., have agreed not to advertise the compound, but to leave its introduction to the profession entirely in the hands of the Drug Addiction Committee. We believe the best method of introduction to be the publication of a clear statement of the drug's properties as nearly simultaneously as possible in the national and state medical society journals and to this end the Committee ask your cooperation.

Will you publish the accompanying statement on Metopon hydrochloride in the RHODE ISLAND MEDICAL JOURNAL at the earliest date possible? If you feel that it is justified, editorial comment on the Committee's program will be appreciated. If you have any questions or suggestions we will be very glad to entertain them, and you may be sure that we, who have nothing to gain except the knowledge of more satisfactory relief of the distress of terminal cancer, will be very glad of your help.

Sincerely,

NATHAN B. EDDY, M.D.

See Page 385 for Report



ARTHUR H. RUGGLES, M.D.

of Providence, R. I.

President of the Rhode Island Medical Society

1947-48

To the Officers and Fellows of the Rhode Island Medical Society

A new year is facing us, and new officers are preparing to guide the Society through what, I am sure we can all agree, will be a most important year. If we continue to make wise and constructive plans for the health of the people of this State, we must do so with a strongly united front and a thorough awareness of what is best for the health of all our people. We can only do this if the public is thoroughly educated into the importance of health measures and how they can best be carried out.

The medical profession has already played an active and important part in the movement to lessen air and water pollution. This has been a notable contribution of the past year, and our efforts can not be lessened in bringing about a still further improvement in the year ahead. We must be mindful of the need of working for sound and progressive legislation in health matters. We must study carefully, not only the needs of the individual, but also the needs of hospitals and clinics, in carrying on and working toward the highest fulfillment of health conditions. This means both the prevention of illness and the treatment of disease.

A number of new out-patient clinics have been established in our State, and more, undoubtedly, will be in the future, as personnel and financing becomes available.

A number of our hospitals are planning extension of their facilities and strengthening of their teaching programs. Kent County is planning a Kent County Memorial Hospital, and the Society must help in every way toward the fulfillment of this much-needed local facility. A new County Society has been formed in Bristol County, and we wish for them steady and strong growth, and a close integration with the parent society.

The Veterans Administration has started to build their hospital, and has established large and active out-patient clinics. Many of our members are serving in various capacities to forward the health work of the Veterans Administration.

My wise and able predecessor has endeavored valiantly to bring into being a voluntary surgical benefit plan. This has not yet been accomplished, but there are many of us who are optimistic enough to believe that a wise, sound and far-reaching plan can soon be effected, and we must not let temporary difficulties stand in the way of voluntary pre-paid surgical care for those desiring it.

All the problems ahead should serve as a challenge and a stimulus to pushing forward our health frontiers and consolidating the worthwhile efforts of the past.

During the War years many of us staggered under a tremendous load of work for the individual sick. Now with the return of many of our members from service, the load is more evenly distributed, and many of us can give a little more time to preventive, educational and organizational development in our State. The proposed Health Federation is an example of future organization in which the Rhode Island Medical Society should play an important part, but in which the help of many lay and professional people will be needed if it is to be a real Federation.

Arthur H. Ruggles, M.D., *President*



MORGAN CUTTS, M.D.
Secretary



CHARLES J. ASHWORTH, M.D.
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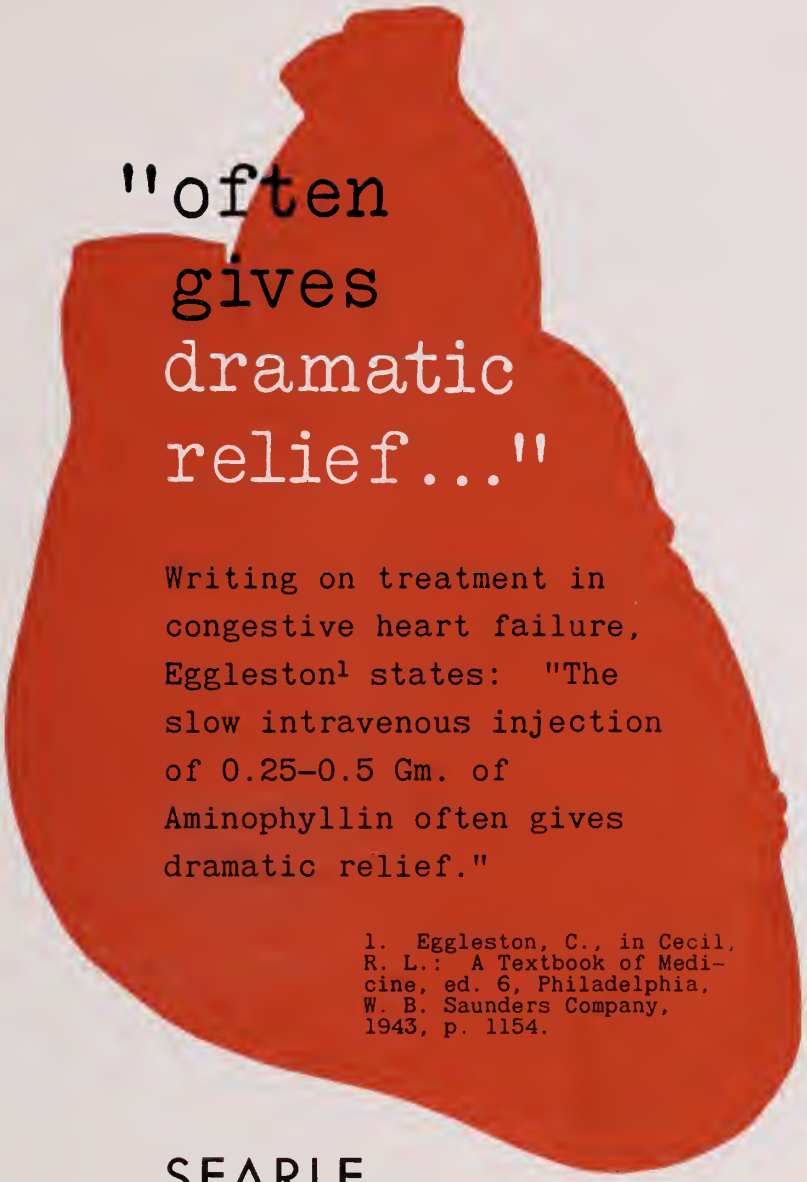
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1. Eggleston, C., in Cecil, R. L.: A Textbook of Medicine, ed. 6, Philadelphia, W. B. Saunders Company, 1943, p. 1154.

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CLINICOPATHOLOGICAL CONFERENCE

RHODE ISLAND HOSPITAL

NAME: A.M.
AGE: 49
Date of first Admission: December 10, 1945
Date of Discharge: January 3, 1946

This 49-year-old man was admitted to the Rhode Island Hospital for the first time in December 1945 with a history of increasing weakness and shortness of breath for about two to three months. He continued at his work as a grocery clerk until six days before admission, when he developed more severe dyspnea, cough and episodes of hemoptysis. He was seen by his physician who felt he was in heart failure. The patient was digitalized and improved some until the night before admission when he had a severe attack of dyspnea, cyanosis, cough and some hemoptysis.

PAST HISTORY:

Patient is said to have weighed 400 pounds in 1935 and on admission weighed in the neighborhood of 250 to 275 pounds. Ten years before entry he was told he had high blood pressure and he had been dieting ever since.

FAMILY HISTORY:

Not significant.

PHYSICAL EXAMINATION:

Temperature 102.2(r); Pulse 98; Respirations 28; Blood pressure 180/150?; Blood pressure (nurses notes) 180/50. The patient was tremendously obese, markedly dyspneic and very cyanotic. Head and neck were normal. The lungs revealed dullness to percussion and diminished breath sounds over the lower half of the right chest and coarse rales at the left base. The heart action was regular. Size could not be made out. A systolic murmur was heard over the entire precordium. The abdomen was obese and a satisfactory examination was not possible. No fluid wave or liver enlargement made out.

LABORATORY FINDINGS ON ADMISSION: December 11, 1945

Blood Chemistry: Urea nitrogen 40; Creatinine 2.5; Glucose 94 milligrams %.

Hematology: Hemoglobin 15.5 grams; White blood cells 7,500; Differential not remarkable.

Urinalysis: Specific gravity 1.012; Protein 2+; Sugar 0; Red blood cells—many; White blood cells—many; Casts 0.

Serology: Hinton Negative.

Sputum: Two concentrated specimens negative for tubercle bacilli.

X-ray Chest: There was increased density in the left hilum, prominent vascular markings in both lungs and considerable free pleural effusion on the right. Heart size indeterminate.

Electrocardiogram: Sinus rhythm: Action, regular. Rate 92. Normal conduction time, TI and II small and diphasic with downward slant of ST segment. TIII inverted. Chest leads showed upright T waves in all positions.

COURSE:

Following admission the patient ran a low-grade fever and a pulse rate varying from 72 to 104 for about one week. Respirations 18 to 40 for about eighteen days during which time he received nasal oxygen continually because of continued cyanosis.

On the night of admission, the right chest cavity was tapped and 600 cc. amber-colored fluid were removed. Specific gravity 1.018. The sediment contained 60 red blood cells; 10 endothelial cells and 40 white blood cells with polys 13%; lymphocytes 85%; endothelial 2%. Culture was sterile. A portable chest plate on December 11, 1945 showed an increase in pleural effusion on the right, a dense hilar shadow on the left and slight deviation of the trachea to the right.

A second chest tap on December 13, 1945 yielded 950 cc. of straw-colored fluid with a specific gravity of 1.020. No pus or organisms were seen in the smear and the differential showed: Lymphocytes 97%; endothelial cells 3%.

He was treated in the usual manner for decompensation. Hemoptysis did not continue. Eight days after admission the blood urea nitrogen was 24 milligrams % and mercupurin was given with "only moderate success". Repeated urines showed a specific gravity varying between 1.010 and 1.013; protein 1+ to 2+; red blood cells 3-10; white blood cells 5-10; casts none. A P.S.P. test showed 25% excretion in 20 minutes and a total of 65% excretion in 50 minutes.

A progress note dated December 26, 1945 indicated that the patient was much improved. No ankle edema or dyspnea was noted and there was only a small amount of fluid at the right base. A

continued on page 362

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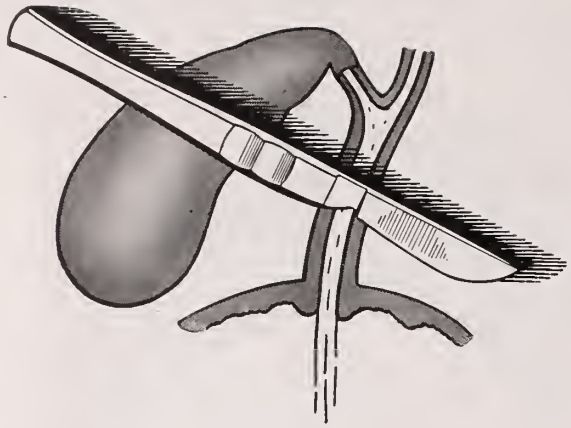
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CLINICOPATHOLOGICAL CONFERENCE

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chest plate taken on the following day showed some clearing of the right upper lung field, a decrease in the pleural effusion and diminution in the size of the left hilar shadow.

A third chest tap was done on January 1, 1946 and 180 cc. of pink fluid aspirated. The smear and differential were essentially the same as on previous taps. The patient was discharged improved on his 25th hospital day, (January 3, 1946) when a repeat electrocardiogram showed minor changes, now with upright T waves in Leads I and II.

SECOND ADMISSION
JANUARY 30, 1946

This patient was admitted a second time 27 days after discharge complaining of increasing dyspnea of several days' duration.

Following discharge he remained a semi-invalid at home. About five days before admission he had an attack of acute tonsillitis for which he was given sulfadiazine for a period of three days. A severe episode of dyspnea followed this for which he was admitted to the hospital.

PHYSICAL EXAMINATION:

Temperature 101; Pulse 80; Respirations 25; Blood pressure 140/100. The patient was orthopneic. The veins of the neck were engorged. No cervical masses. The chest showed equal expansion. The lungs contained fine moist rales at both bases without definite signs of pleural fluid though the breath sounds were distant. The heart action was regular. No murmurs were heard. Satisfactory examination was difficult due to the size of the patient. The abdomen was markedly obese. No masses felt. The extremities showed no edema or clubbing.

LABORATORY FINDINGS:

Blood Chemistry: *January 31, 1946:* Urea nitrogen 15; Glucose 86.
February 8, 1946: Urea nitrogen 26; Creatinine 2.3.
February 12, 1946: Urea nitrogen 28; Creatinine 1.7; Cholesterol 186; Protein 5.7.
February 14, 1946: Acid phosphatase; Alkaline phosphatase normal.

Hematology: *January 31, 1946:* Hemoglobin; White blood count and differential normal.
February 8, 1946: White blood count 12,800; Differential normal.

Urinalysis: Specific gravity 1.008 to 1.011; Protein 1+ to 2+; Red blood cells 20 to loaded; White blood cells 10 to loaded; Casts none. Fishberg concentration test 1.012.

X-ray Chest: January 30, 1946

Lower half of right lung field obscured by dense shadow, increasing in density toward the base. Similar findings at extreme base of left lung. Enlargement of left hilum shadow now extending to the middle of the left lung field. Supracardiac shadow widened bilaterally. Trachea in midline.

Subsequent chest films showed clearing in both lung fields, due in part to variation in technic. No definite pleural effusion. Shadow in center of the left lung field showed some increase in size.

Electrocardiogram: January 31, 1946

Same as January 3, 1946.

February 7, 1946: Still unchanged. Occasional auricular and ventricular ectopic beats.

INTRAVENOUS PYELOGRAM: February 10, 1946

A large stone was found in the left kidney and multiple stones in the right. Question of multiple cavities in the right kidney.

Urine Culture: February 13, 1946: Hemolytic streptococcus; staphylococcus aureus, coagulase negative.

Urine Sediment: 30 Red blood cells and rare white blood cells per high power field.

COURSE:

The patient ran a low-grade fever, a varying pulse rate from 80 to 110 and an elevated respiratory rate (18-60). He seemed to improve with oxygen and digitalis therapy until the 14th hospital day when he was found lying on the floor very dyspneic, cyanotic and perspiring profusely. Both lungs were filled with bubbling rales. Blood pressure 140/70; pulse 130. Cyanosis persisted in spite of oxygen. Venous pressure in left arm was 550 millimeters saline. Rotating tourniquets were tried without success and patient expired about 12 hours after being found on the floor.

CLINICOPATHOLOGICAL CONFERENCE

February 4, 1947

DR. CLARK: Our case today is discussed by Dr. Frank Cutts.

DR. FRANK CUTTS: I have read this over several times and I must say I have no positive diagnosis that I can make.

In summary, we may say that this patient is an obese male, complaining of dyspnea, cough, cyanosis and hemoptysis. There was some fever, and there was a question of hypertension, and signs

continued on page 364



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CLINICOPATHOLOGICAL CONFERENCE

continued from page 362

of fluid at the right base. There was minimal nitrogen retention. There was a normal white count, and many red and white cells in the urine. The chest taps showed clear fluid, with a relatively high specific gravity and the cells were chiefly lymphocytes. He was re-admitted, again for dyspnea. The urine was still loaded with red cells. There were peculiar lung shadows. Also, as the x-rays will demonstrate, he apparently had bilateral renal calculi. There was the terminal episode of dyspnea and cyanosis.

I think we may now look at the x-ray films. These are arranged in chronological order.

DR. MARTINEAU: The first film was taken the 10th of December, on the first admission, and showed uniform density in the lower part of the right chest, obscuring the underlying lungs, which we felt was a considerable effusion. It wasn't mentioned at this time, although I think you can see here a diffuse widening of the shadow here at the left of the aorta. There is a mediastinal mass here. The whole lung has an opacity throughout that may well go with a pulmonary congestive change.

I think the striking thing here is the widening of the mediastinal shadow, and this mass here, which would lead you to believe, that there was a neoplasm, and with pleural involvement present.

DR. CUTTS: Then, more films were taken three weeks later.

DR. MARTINEAU: We felt that most of these changes were due to changes in technique. He was a very heavy fellow, and it was difficult to get contrast on our films. We felt we couldn't be sure of the cardiac size because the heart was obscured at all times by the uniform density in the right lung.

This one (showing film) was taken on the second admission, January 30, 1946, and I think there is a definite increase in the density in the right lung. There is no change anywhere else.

DR. CUTTS: Do you want to rule out tuberculosis from that appearance?

DR. MARTINEAU: I think it could, yes. But, I don't think you can rule out infection, or a lot of other conditions. It is not unusual to get infection associated with bronchial stenosis, regardless of the cause. You may have some accompanying secondary infection of the lung.

I am inclined to believe there is atelectasis and secondary infection.

An intravenous pyelogram showed a large calculus on the left, forming a cast of the dilated calices and pelvis, with calculi also on the right.

Here is a lateral view of the chest, taken at the same time, and I think this demonstrates very well the mediastinal involvement; here is the mass displacing the trachea way forward just below the sternum. Then, the lower lobe shows fairly good aeration except for some patchy infiltration.

DR. CUTTS: Would you speculate about the heart size in the lateral view?

DR. MARTINEAU: I think we can see it here. I would believe it was within normal limits, for his height and weight. There is no encroachment here upon the retro-cardiac space. I am inclined to believe the heart isn't enlarged.

DR. CUTTS: First, we must try to decide what organs and systems are involved, and then see if we can piece it together, and try to fit it in with one diagnosis, and if we cannot do that, to indicate what multiple diagnoses we should try to consider.

First of all, in view of the initial symptoms, I raise the question of heart disease. In favor of that, we have a history of hypertension, a story of dyspnea, which is quite consistent, and cough. There were also signs of pulmonary edema and fluid. And, there was a questionable murmur heard on one occasion. Against it, there was no clear evidence of high blood pressure, as recorded during the stay in the hospital, and no convincing evidence of valvular disease, no story of pain. He had no edema recorded in his record, and I think this would be expected with this degree of dyspnea and cardiac failure. Moreover, my impression, and Dr. Martineau's impression, also, was that it was a normal sized heart, which again is evidence against the diagnosis of heart disease. Finally, there was not a remarkable electrocardiogram. In my experience, it is extremely rare to have a patient dying of heart disease, with a normal electrocardiogram, if we exclude those who die suddenly with angina. Therefore, I doubt the presence of heart disease. If he has it, I don't know what kind it is.

Next, pulmonary disease. There was dyspnea and hemoptysis, cyanosis, and fluid in the chest, in which many lymphocytes are present. There were engorged neck veins, suggesting mediastinal involvement. In the x-rays, as we have seen, he has these peculiar lobular shadows, and he seems to have improved somewhat while here. I wonder what the significance of that is. Does it mean that he had better respiratory function as a result of chest taps and removing of his fluid? We note in passing two negative sputums for tuberculosis.

As far as the kidneys are concerned, next, I want to consider in favor of kidney disease the low specific gravity, the persistent albumen, the persistent red and white cells in the urine, and the clear-cut evidence of large, renal calculi. He has kidney stones. I can bet on that with a reasonable degree of assurance. There was no B.U.N. elevation, so

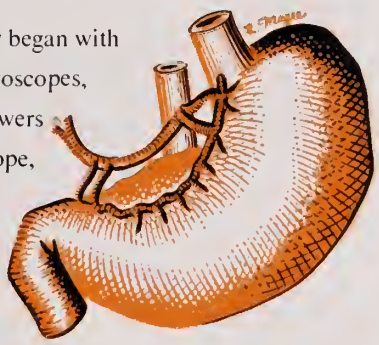
continued on page 368

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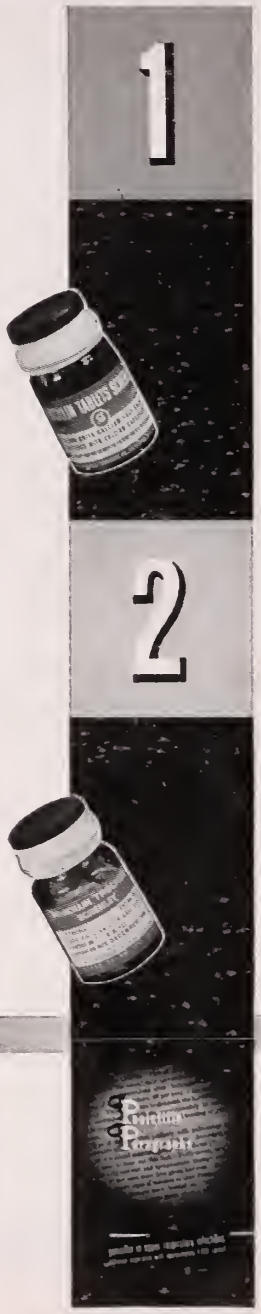


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CLINICOPATHOLOGICAL CONFERENCE

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we have no justification for saying that he died in uremia. He must have had some reasonably adequate functional renal tissue remaining.

Now, to try to speculate as to what is causing these things; as regards the lungs, we have to decide between infection or neoplasm. We note that there is no elevation of his white count. The fluid in the chest contained mostly lymphocytes. He had a hemoptysia, which again is consistent with parenchymal tuberculosis.

Regarding neoplasm, that could be primary or secondary, although, hemoptysis is more common with primary maligancy. However, it has been known to occur with metastases from the kidney which encroach on and erode bronchi.

In favor of neoplasm we have x-ray evidence which suggests some increase in the size of the mediastinal mass.

One thing that might be mentioned is the possibility of pulmonary emboli, which could cause attacks of dyspnea and mediastinal engorgement. I have no way to rule it in or out.

As far as the kidneys are concerned, we have proven infection with streptococci. The stones are a perfectly adequate cause for the white and red cells in the urine. With kidney stones, we might think of hyperparathyroidism, but I believe the diagnosis unlikely. I believe this degree and type of renal calcification in hyperparathyroidism does not occur.

Well, now, to sum up and try to arrive at a guess. If we try to include all that he shows in one diagnosis, I can only think of one that fits it reasonably well, and that is tuberculosis. He could have tuberculosis of the kidneys over a long period of time. We know it can result in calcification and stone formation. Dr. Williams has shown us cases of renal tuberculosis ending up with a tuberculosis meningitis, miliary tuberculosis, or secondary pulmonary tuberculosis. So I think he could have had tuberculosis of the kidney, with mediastinal and pulmonary tuberculosis, and obstruction to his veins from his upper extremities.

That is the only single diagnosis that I can think of that explains all we see in this patient.

The next possibility is renal stones, and primary carcinoma of the bronchus, with wide metastases, which again could account for the mediastional engorgement.

Pulmonary emboli are possible.

There are other remote things, like actinomycosis, but the evidence is much too tenuous seriously to consider them.

We are told, at times, that in people under fifty, we should try to settle for one diagnosis, and with those who are over fifty, it is more common to have two. He is forty-nine, so take your choice.

I am not able to make a positive diagnosis; however, I will say that I think the most likely diagnosis is renal tuberculosis, with secondary pulmonary and probably miliary tuberculosis.

As a second bet, I would put down neoplasm in the chest, probably carcinoma of the bronchus, with wide-spread metastases; and third, neoplasm somewhere else in the body, with multiple metastases of the chest — both the latter with co-existing renal calculi.

DR. CLARK: We should have some questions on this case.

DR. BURGESS: I would like to mention this, and Dr. Wing and Dr. Cook are here and they would remember the instance. In the Naval Hospital, during the last war, we were studying a patient extensively, with x-rays almost exactly like this case with a little larger heart shadow. The patient had mediastinal tuberculosis, with encroachment on one lung, and it was very similar to this.

I feel the doctor summarized this case very well.

DR. PERRY: I would like to ask if the renal x-rays are what you see in tuberculosis?

DR. MARTINEAU: No; I think the calcification is more apt to be in the parenchyma of the kidney. Usually, there is a stricture of the calix, due to scarring and fibrosis, and a deformity there.

I think it is a case of renal calculi, with calcification.

DR. KRAMER: I might suggest another possibility. Hypernephroma, with metastases into the lungs; that is a possibility.

DR. CORVERSE: I think this might be a so-called masked bronchiogenic carcinoma, with early obstruction of the bronchus. A second thought would be those other things due to secondary infection, and there is a possibility of hypernephroma; at least I believe that you can consider it.

DR. HAM: I think the absence of high fever in the man and his eventual recovery after the first admission are a pretty much against it being an active miliary tuberculosis. It is pretty hard to explain, on the basis of miliary tuberculosis. I think the tumor may be on the basis of tuberculoma. I would suspect more likely a mediastinal neoplasm, of a non-infectious nature, the type of which I wouldn't want to say.

DR. CHASE: With a mediastinal tumor, the first thing to think of, of course, is a lymphoma. I don't know about the process going out in the lungs. I would like to ask Dr. Martineau about that.

continued on page 370



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CLINICOPATHOLOGICAL CONFERENCE

continued from page 368

DR. MARTINEAU: I think if the mass is large enough, and they have enough bronchial glands, and give enough compression, all right; I think the density in the right lung is merging out from the hilum and so ill-defined that the lateral margin is due more to atelectasis. The density in the right lower lobe looks more inflammatory and not unusual. I don't think you can rule out a malignant lymphoma at all.

DR. CLARK: Are there any further suggestions?

DR. SHARP: I don't believe the terminal event fits in with the other clinical findings. Something new has been added, when he died. Something of the nature of a breaking through of the blood into the pericardial sac, giving an increase in venous pressure and a distention of the neck veins and a profound change in the patient. I don't know if there is any connection between the madiastinal shadow and what was found terminally, which I think is in the pericardium.

DR. CLARK: Are there any further suggestions?

DR. FULTON: Dr. Clark, would it be of interest to report what the service thought of this man?

DR. CLARK: Yes, of course.

DR. FULTON: At the time of admission, the diagnosis was cardiac decompensation, due to hypertensive cardiovascular disease, and a question of coronary. He was largely treated for the cardiac condition during the first admission. His discharge diagnosis when he first went home was: Hypertensive cardiovascular disease and cardiac insufficiency. That same diagnosis held at the time of readmission, and, as more evidence came along from the x-rays and the patient's course of illness the second time, there were these diagnoses suggested:

Question of hypertensive cardiovascular disease, with left ventricular failure, with one question mark before it and three after it.

The second one was, question of mediastinal tumor, with secondary cardiac; question of bilateral nephro-lithiasis.

DR. CLARK: On the first admission, they were largely concerned with the heart, and later on, they apparently thought more about the neoplasm. This has proved to be something of a pathological museum.

I don't know how to start, but perhaps in the same order Dr. Cutts did, with the heart first. I don't know that we can correlate with the clinical findings. But, the heart is somewhat enlarged; it weighed 600 grams. And, even for a man of his size, it is large. When we examined it, the left ventricular wall was definitely thickened, and the cavity was not dilated. So I think he has ventricular hypertrophy, which we can accept as he has a history of ten years of high blood pressure. The right heart is particularly enlarged, and the right ventricular wall is surely three times the thickness of the normal ventricular wall.

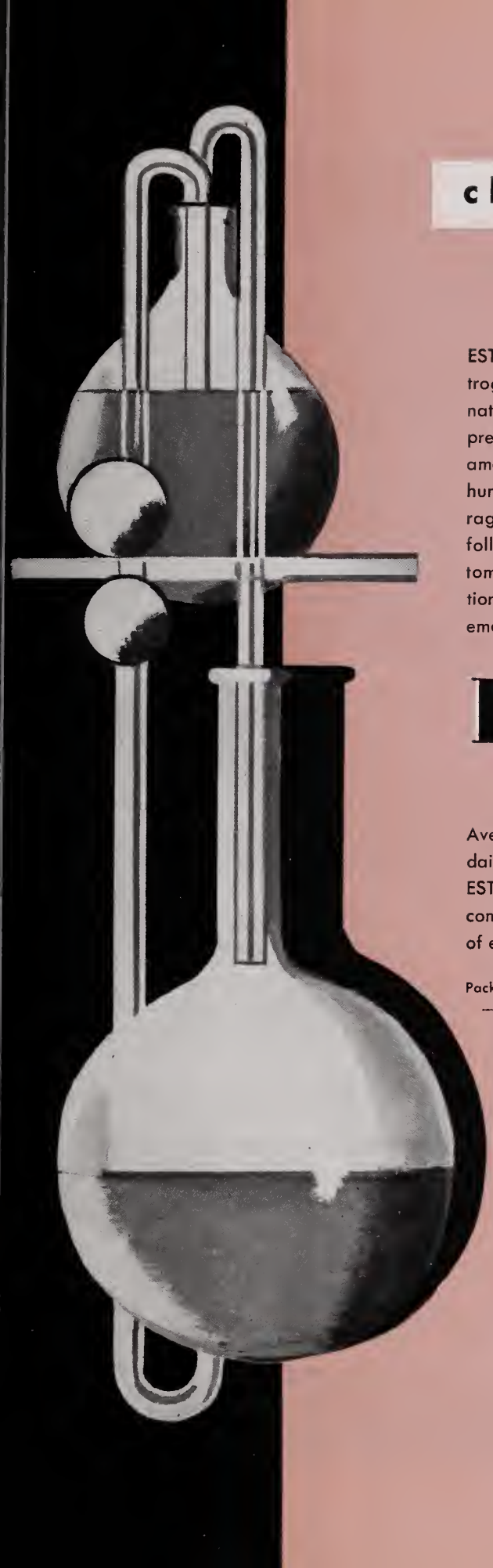
Now, we come to the chest. There were 660 c.c. of fluid in the right chest, and 50 c.c. on the left. We have the lungs here. If we look at them first from behind, we see that here, at the hilus and the mediastinum, there are some large lymph nodes that have been cut across and appear definitely to be neophlasm. Then, if we open up the trachea and bronchi and follow them, we find that on the right side, those main branches become narrowed, and apparently they cannot be followed very far. If we then turn the specimen over, and cut the lung in two parts, we can see where the main branches of the right bronchi go; this represents the upper and this is the lower, while the middle is not to be seen at this location [referring to specimen]. All about them, but apparently originating about the middle lobe, is this hard, white tumormass, which has extended directly into the upper lobe and into the lower lobe. It appears that it originated in the middle bronchus. Here is a remnant of the middle bronchus that can be seen way out here. The probe could not be inserted in this direction, so the bronchus is occluded. So that while the tumor involves really all three lobes, the lower one not so much, it appears to be originating in the middle bronchus, and extending to the mediastinal structures and the adjacent lung. There are, in the left upper lobe, several large nodules of tumor tissue, and those are probably what showed in the x-ray film. Then, there are scattered, smaller nodules to be seen in the lower lobe.

Now, we will put this back together and again we see posteriorly the arch of the aorta coming in here [indicating] and here is the vena cava laid open, and projecting out into it is this mass, which looks something like a thrombus, because it has a red hemorrhagic surface. If we open it up again, we see the tumor tissue has extended through the wall here and into it, greatly reducing its lumen.

Now, in addition to that, in the left lung, there was found a single tumor in the tissue, only 1½ c.m. in diameter, and there was in the left adrenal gland a tumor mass 4 c.m. in diameter. In the small intestine, about the middle of the jejunum, a little nodule was seen on the mucosa.

Now, I want to come back to those more distant ones in a moment or so.

continued on page 372



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1. Bickers, W.: Am. J. Obst. & Gynec. 51:100, 1946.

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CLINICOPATHOLOGICAL CONFERENCE

continued from page 370

We come now to the examination of the kidneys. First, we look at the right kidney. It is very, very small, and if we open it up and look down into the pelvis, here is a calculus which is inserted into the uretero-pelvic junction and occludes it. The kidney tissue is markedly reduced, and the pelvis dilated. The surface of the kidney shows scars of various sizes, but there is so little normal tissue left that it is pretty much one big scar. So that we have a markedly reduced kidney, and I think undoubtedly on the basis of infection, pyelonephritis, and pyelonephrosclerosis.

Then, if we look at the other kidney, we find that it is quite large [showing specimen] and apparently has hypertrophy, which no doubt has been going on for a long time. The lower pole is markedly enlarged, and the orifice is there [indicating], while in the upper part of the pelvis are these great, hard stones, which showed in the x-ray film. But this is limited to the upper part of this kidney, and it seems evident that with this hypertrophy remaining, he was able to carry on reasonably well, so the patient did not have renal failure, but he does have bilateral renal calculi, and pyelonephritis in one kidney [indicating].

I want next to show you some histology. First, I show you the histology of the lung tumor. It is customary to divide primary carcinoma of the lung, on a histological basis, into three groups. One, which is called an epidermoid, resembles an epidermoid carcinoma elsewhere. The second, which is glandular in structure, is called adenocarcinoma. Then a third, in which the cells are very small, and undifferentiated sometimes called round cell carcinomas, or, because not infrequently they have a sort of elongated shape, the British are quite fond of calling them oat cell carcinoma of the lung.

The histology of the tumor is quite uniform. Each of these masses occupies an alveolus. Regardless of where you look at the tumor, the cells are all the same. Out here in the adjacent tissue, there is atelectasis, and chronic infection. About the adjacent vessels, the lymphatics are plugged with extensions of the tumor. With a higher magnification, you can get a better idea of the cells.

Here is a section of the liver, with the metastatic nodules in it. Again, the histology is identical, so far as the tumor is concerned, and you can see the adjacent liver tissue.

Now, we come to the adrenal gland, and here in the cortex of the adrenal gland is a tiny nodule that

continued on page 382

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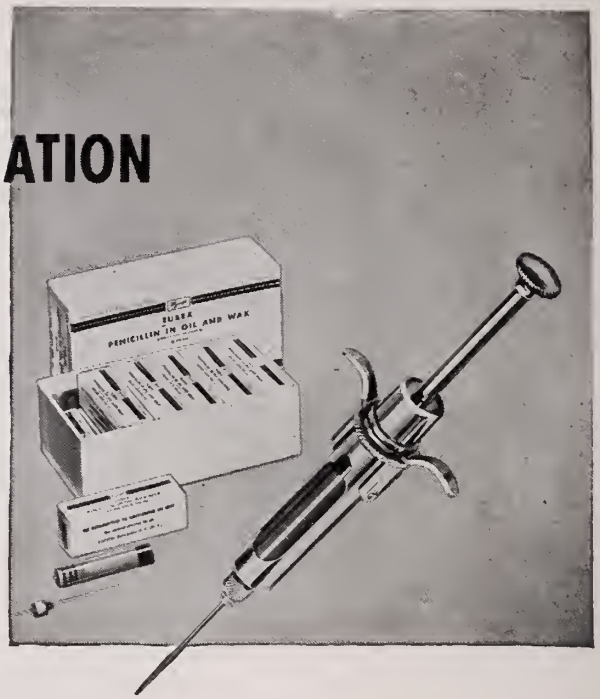
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DISTRICT SOCIETY MEETINGS

PAWTUCKET MEDICAL ASSOCIATION

The annual meeting of the Pawtucket Medical Association was held March 20, 1947, in the Castle Room of the Sheraton-Biltmore Hotel in Providence.

A cocktail hour and banquet preceded the business meeting during which time Miss Loretta Beech, accordionist and vocalist, entertained.

Dr. William N. Kalcounos called the business meeting to order. Dr. Edward Foster made a motion that the reading of the records of the previous meeting be dispensed with and this motion was speedily passed. Dr. Charles L. Farrell moved that the reading of the records of the previous annual meeting be omitted. This motion was passed. Dr. Harry Hecker moved that the Secretary omit reading the list of all Active, Associate, and Honorary Members. This motion was passed. The reports of the Secretary and the Treasurer were read and approved.

Dr. William N. Kalcounos, President, gave a brief address mentioning that many accomplishments had been achieved but that many were to be faced.

Dr. Kalcounos then asked the Secretary to read the names of the Association Officers for the coming year as selected by the Nominating Committee. They were as follows:

President: Earl J. Mara, M.D.
Vice President: John H. Gordon, M.D.
Treasurer: Lawrence A. Senseman, M.D.
Secretary: Kieran W. Hennessey, M.D.
Councillor: Earl F. Kelly, M.D.
Alternate Councillor: Edward H. Trainor, M.D.
Delegates:
Earl J. Mara, M.D.
Charles L. Farrell, M.D.
Henry J. Hanley, M.D.
Robert T. Henry, M.D.
Standing Committee:
G. Raymond Fox, M.D.
Joseph H. Doll, M.D.
Edward H. Trainor, M.D.
Armand A. Bertini, M.D.
William N. Kalcounos, M.D.

As no counter nominations were offered, Dr. Albert Gaudet moved that the Secretary be empowered to cast one ballot for the slate as presented. The motion was passed.

Thereupon, the newly elected President, Dr. Earl J. Mara made a brief speech of acceptance and turned the meeting over to Dr. Gaudet who presided as Master of Ceremonies. Dr. Gaudet mentioned the regrets expressed by Dr. Pitts, President of the Rhode Island Medical Society, and Dr. Guy Wells, President of the Providence Medical Association, and Mr. John E. Farrell, Executive Secretary of the Rhode Island Medical Society, all of whom were unable to attend the annual meeting because of previous commitments.

Two members of the Central Council of Alcoholics Anonymous were introduced by Dr. Gaudet and the aims and nature of that organization were unfolded in graphic detail. Following the discourse, both speakers answered questions from the floor and distributed pamphlets to those interested.

The meeting adjourned at 11:00 p. m.

Fifty-nine members attended the meeting.

Respectfully submitted,

KIERAN W. HENNESSEY, M.D.,
Secretary

KENT COUNTY MEDICAL SOCIETY

A meeting of the Kent County Medical Society was held on March 4, 1947, at Dr. Erinakes' office. At 9:00 p. m. a film was shown on the use of Pentothal Sodium for general anesthesia. It was presented by Mr. James Searle from the Abbott Laboratories, and a vote of thanks was offered to Mr. Searle and Mr. Farrell of Abbott's.

At 10:00 p. m. the meeting was called to order. There were fifteen members present. Dr. Erinakes read the minutes of the last meeting. A motion was made by Dr. Tefft, seconded by Dr. Hardy, that the minutes be accepted as read, and the motion was carried.

The President, Dr. Erinakes, then read a letter from the Red Cross, soliciting a contribution for their current drive. A motion was made by Dr. Hardy that an answer be sent to the Red Cross, explaining that the Society has no funds for such contributions and that the donations are made individually by each member. The motion was seconded by Dr. Davies and it was unanimously carried.

continued on next page

KENT COUNTY MEETING

continued from preceding page

Dr. Mack then read a paper on "Headaches" and stressed the importance of dietetics in its prevention and treatment.

The meeting was adjourned at 10:25 p. m., followed by a luncheon donated by the President. A vote of thanks was made to him by Dr. Tefft, in the name of all the members present.

Respectfully submitted,

JOSEPH K. HARROP, M.D.,
Secretary

The April meeting of the Kent County Medical Society was held at the office of its President, Dr. Peter C. Erinakes, and was called to order at 9:45 p. m., April 1, 1947.

Prior to the meeting proper, a very interesting film on Gastric and Duodenal Ulcer was shown by representatives of the Wyeth Pharmaceutical Company.

Because of the late hour, further Society business was deferred and the guest speaker, Mr. John E. Farrell, Executive Secretary of the State Medical Society, was immediately received.

Mr. Farrell spoke very ably and from apparent wide background study on the problem of Socialized or State Medicine. Pertinent highlights, lay, professional and economic, were fully developed and later became topics of a well participated round table discussion.

This interesting meeting was adjourned at 11:00 p. m.

FRANCIS LAMB, M.D.,
Secretary, Pro tem

NEWPORT COUNTY MEDICAL SOCIETY

In lieu of the regular bi-monthly meeting of the Newport County Medical Society the members attended, at the invitation of William H. H. Turville, Capt. (MC) U.S.N., Commanding Officer of the Newport Naval Hospital, a special staff meeting of that hospital on Tuesday evening, March 25, 1947, at 8:30 p. m.

The program consisted of a presentation of three papers by members of the Naval Hospital staff:

1. "Biliary Fistulae with Case Report"
   presented by Capt. R. E. Baker (MC) U.S.N.
2. "Survival Following Castration for Prostatic Carcinoma"
   presented by Lt. (j.g.) T. H. Frazier (MC) U.S.N.R.
3. "Diverticulae"
   presented by Comdr. J. J. Timmes (MC) U.S.N.

Following the presentation of the papers, a discussion was held and those present then adjourned to the Bachelor Officers Quarters where a collation was served.

Respectfully submitted,

HENRY W. BROWNELL, M.D.,
Secretary

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, April 7, 1947. The meeting was called to order by President Guy W. Wells at 8:30 p. m.

The Secretary read the minutes of the previous meeting.

The President announced that from the committee of Doctors Arthur H. Ruggles, Paul C. Cook, and George W. Waterman had been received the tribute to the late Dr. Bertram H. Buxton; and from the committee of Doctors Mihran Missirlian and Mihran A. Chapian had been received the tribute to the late Dr. Hampartzum Gulesserian. These tributes have been placed on file by the Secretary, and copies will be transmitted to the families of the deceased.

The President asked the members present at the meeting to stand for a moment in prayer to the memory of the deceased members of the Association.

The President announced that he had appointed as a committee on health and safety to cooperate with the committees of the city in its Clean-Up Providence Program Dr. Anthony Corvese, Chairman, Dr. Paul C. Cook, Dr. Peter F. Harrington, and Dr. Joseph Smith.

The President announced that in view of the fact that the Bristol County Medical Association has been chartered as a constituent society of the State Medical Society, thus removing it from the jurisdiction of the Providence Medical Association, it would be necessary for him to appoint a Delegate to fill the vacancy created by this action. Therefore, he announced that he was naming Dr. Walter S. Jones of Providence to fill the unexpired term of Dr. Robert Drew of Warren as a Delegate named by the Providence Medical Association to the House of Delegates of the Rhode Island Medical Society.

Dr. Guy W. Wells, President, announced that he was appointing Dr. C. Thomas Angelone and Dr. Angelo Scorpio to serve as a committee to prepare the Association's tribute to the late Dr. Salvatore Castallo.

The first speaker of the evening, Dr. Ira T. Nathanson, who spoke on "Hormonal Alteration of Carcinoma of the Breast," stated that the relation-

continued on page 378



World of new hope in petit mal

One important fact stands out in the rapidly expanding clinical record of Tridione: Thousands of children formerly handicapped in school and play by petit mal, myoclonic or akinetic seizures are finding substantial relief through treatment with Tridione. In one test, Tridione was given to 150 patients who had not received material benefit from other drugs.[11] With Tridione, 33% became seizure free; 30% had a reduction of more than three-fourths of their seizures; 21% were moderately improved; 13% were unchanged, and only 3% became worse. In some cases, the seizures, once stopped, did not return when medication was discontinued. Tridione also has been shown to be beneficial in the control of certain psychomotor epileptic seizures when used in conjunction with other antiepileptic drugs.[12] Wish more information? Just drop a line to ABBOTT LABORATORIES, North Chicago, Illinois.

Tridione (Trimethadione, Abbott)
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12. DeJong, R. N. (1946), Further Observations on the Use of Tridione in the Control of Psychomotor Attacks, Am. J. Psychiatry, 103:162, September.

PROVIDENCE MEDICAL ASSOCIATION

concluded from page 376

ship of the ovaries to breast disease was early recognized. Before radium was used it was observed that removal of the ovaries exerted a favorable influence on carcinoma of the breast. Castration is used in premenstrual women. It is not beneficial after the menopause. Irradiation castration is not as good as surgical. Also, castration exerts its best effect on soft tissue disease. Castration should be used on advanced or recurrent disease.

Male hormone used in female had no gross effect on the primary lesion. In some the male hormone seemed accelerate bony metastases, but it did relieve pain; however, he treated many patients with advanced disease of breast with massive doses of stilbestrol and the lesions diminished and were ameliorated. Some of those advanced cases remained quiescent for twelve to eighteen months.

Testosterones good for bony metastases causes calcification. Testosterone works by increasing the metabolic effect and has no immediate effect on the tumor.

The second guest speaker was Dr. Grantley Walder Taylor, who spoke on "Lymphatic Spread of Carcinoma and Its Management."

Small emboli of cancer cells break off and are carried via the lymphatics to the regional lymph-nodes. There they are enmeshed in lymph tissue and start a growth there.

In time, as the lymphatic channels are plugged with cancer cells, collateral lymphatics become involved.

In addition we get metastatic cells from the lymph nodes to other areas.

At times, particularly in the later stages, a solid thrombus of cancer may extend from the primary site along the lymphatic. The usual mechanism, however, is by emboli to nearest node.

The greater the malignancy the greater the propensity to spread to lymph nodes. Massage and muscular activity hasten the spread. Too frequent examination may aid this spread.

In treatment, all the disease must be removed as well as all involved nodes. In the case of skin, extremities, mouth and lip, surgical attack on the nodes is done later, since the first operation is formidable.

A large number of patients are cured when an attack is made at the same time or a later date on nodes, and the presence of node metastases should not discourage one from getting a cure.

The meeting adjourned at 10:30 p. m.

Attendance: 104.

Collation was served.

Respectfully submitted,

DANIEL V. TROPPOLI, M.D.,

Secretary



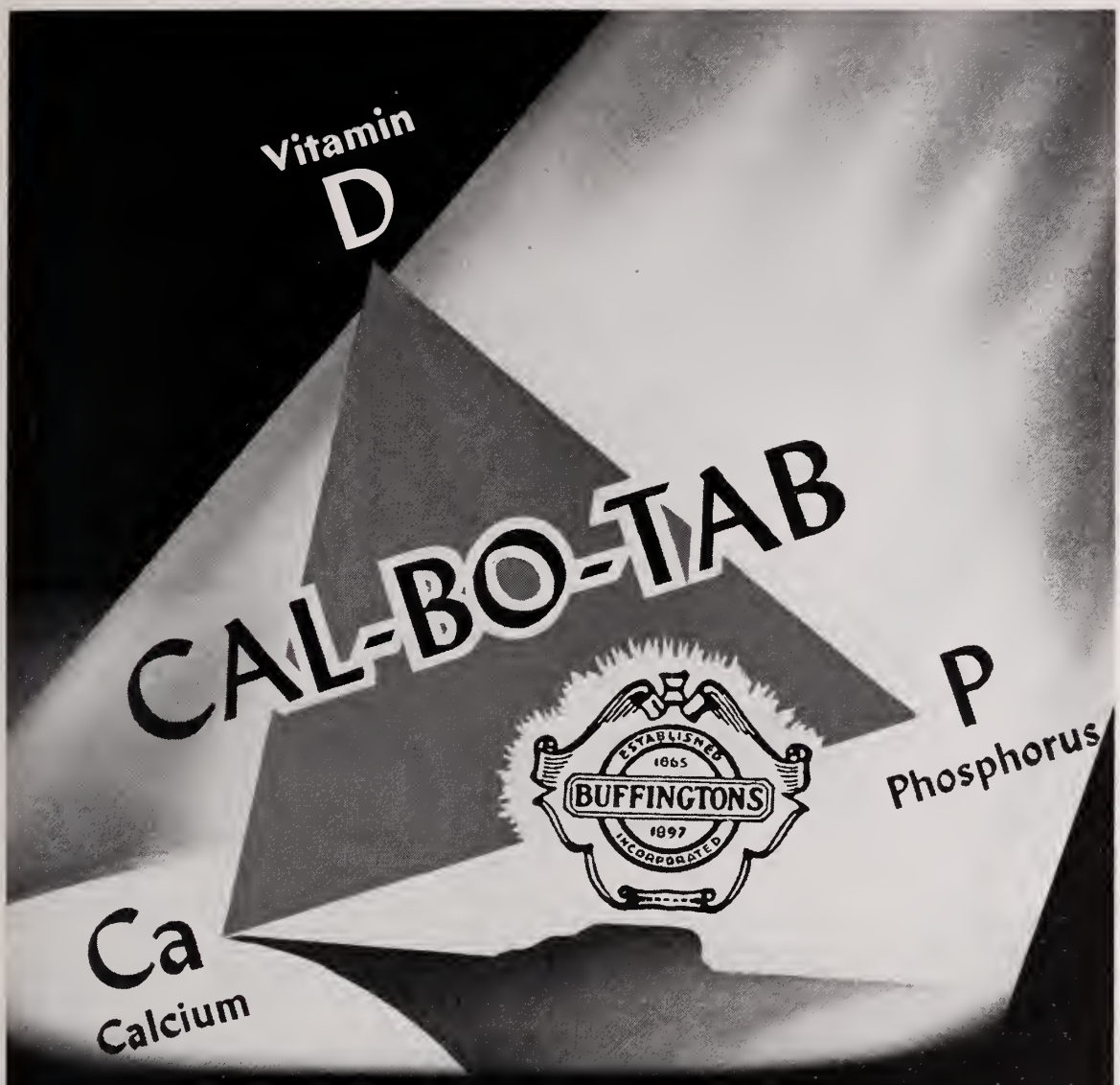
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HOSPITAL ASSOCIATION OF RHODE ISLAND

REPORT ON RECENT ACTIVITIES

(Prepared by Helen M. Blaisdell, R.N., Superintendent, Westerly Hospital)

NEW ENGLAND HOSPITAL ASSEMBLY

The New England Hospital Assembly, comprised of hospital administrators of all the New England states, held the 24th annual meeting in Boston, March 24th, 25th and 26th, 1947, in the Hotel Statler. The attendance numbered 3000, which also included assistant administrators, heads of hospital departments and guests.

The exhibits of hospital suppliers were the best ever. It is encouraging to again see hospital equipment available but deliveries are still slow.

The program was enthusiastically received. This was particularly gratifying to the Program Committee, on which Rhode Island hospitals were represented. The following members who served were Dr. Arthur Ruggles, Superintendent of Butler Hospital; Mr. Carl Lindblad, Superintendent of Roger Williams Hospital; Miss Helen M. Blaisdell, R.N., Superintendent of The Westerly Hospital.

Other representatives of Rhode Island hospitals who took part in the section or general meetings were:

Rhode Island Hospital
Mr. Oliver Pratt, Superintendent; Dr. Henry Joyce, Assistant Superintendent; Mr. Walter Comee, Personnel Director; Mr. John Latcham, Assistant Director

Butler Hospital
Dr. David Wright, Assistant Superintendent; Mr. Arthur Almon, Jr., Personnel Director; Mr. J. W. Tingley, Maintenance Engineer

Charles Chapin Hospital
Dr. Robert Garrard, Director Neuro-psychiatric Department

Wanskuck Company, Providence
Mr. Carl E. Gill, Director Industrial relations

At a luncheon for the Hospital Association of Rhode Island, there were 47 in attendance; superintendents, and assistants, heads of various departments, including many nurses, and the director of the Rhode Island Blue Cross. For many of the nurses it was their first hospital convention and they expressed having derived much benefit from the meetings and exhibits.

One of the most interesting meetings, and extremely well attended, was conducted by Mr. Carl Lindblad, subject: "Nursing Service", with the subtitle "Where, Oh Where, Has The Little Nurse Gone?" Animated discussion followed the prepared papers regarding the merits of a five year course for all nurses in training, the elimination of the three year course, and the adoption of a short course for practical nurses. The licensure of practical nurses was considered advisable as a protection to the public. No definite decisions were arrived at but those in attendance were supplied with ample food for thought. The subject of nursing service is of such vital importance it will necessarily appear on every future program of every meeting of hospital administrators and possibly of medical organizations. Frank discussion of our common problems are bound to prove beneficial even though the subject matter, at first presentation, sounds revolutionary.

NEW ENGLAND INSTITUTE FOR HOSPITAL ADMINISTRATORS

The third New England Institute will be held at Brown University, June 19th to 28th, 1947. Dr. Wriston, President of Brown University, is honorary chairman of the Institute committee and Mr. Oliver T. Pratt, Executive Director of the Rhode Island Hospital, and president of the Hospital Association of Rhode Island, is director of the Institute, which is to be conducted by the American College of Hospital Administrators in affiliation with the New England Hospital Assembly and the hospital associations of the six New England states.

The membership will include administrators and assistant administrators of hospitals in New England, although a limited number of individuals outside of New England may be admitted. Registration will be limited to 100. All the students will live on the campus at Brown University. The Institute will provide opportunity for hospital administrators to review the fundamentals of hospital administration and obtain instruction in advanced and special phases of hospital administration. An excellent curriculum is being prepared and field trips to various hospitals for practical demonstrations are being arranged.

continued on page 382



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HOSPITAL ASSOCIATION NOTES

concluded from page 380

A meeting was held on April 9, 1947 at Roger Williams Hospital. The purpose of the meeting was to dissolve the Hospital Association of Rhode Island and reorganize as a corporation. Legal advice as to proper procedure for incorporation was rendered by Mr. George Davis, attorney. The organization will hereafter be known as the Hospital Association of Rhode Island, Inc. The reason for incorporation was the fact that it will be of value to the association in presenting bills to the State Legislature.

At this meeting, the matter of Workmen's Compensation rates were discussed. The bill for the change in such rates was recently passed by the Legislature and has been signed by the Governor. The new rates will be the current private ward rate in each hospital, not to exceed $8.00 per day.

The members of the Hospital Association were the guests of Mr. Carl Lindblad, Superintendent of the hospital, at an excellent dinner.

The next meeting of the Hospital Association will be held June 4th, as the guests of The Westerly Hospital, Westerly, R. I.

The Westerly Hospital has now been a member of the Institute of Pathology for ten months and the results have been very satisfactory. Dr. Clark, the Pathologist from the Rhode Island Hospital, attends all of the staff meetings at the Westerly Hospital and his chemists and pathologists supervise the laboratory and technicians. The hospital purchased a microtome for the use of the pathologists and excellent service has been supplied by the pathologists in making frozen sections. Tissue examinations are made at the Rhode Island Hospital. More autopsies have been performed since connection with the Institute. Continued association with the Institute will bring even greater benefits to the hospital.

The hospital Roentgenologist, Dr. Field, also attends all staff meetings at the hospital, which has proved very beneficial to the medical staff.

New equipment received at the hospital recently is as follows: 3 infant incubators with oxygen therapy equipment and humidifiers, one Basal Metabolism apparatus. These were donations. The money has also been donated for a new Electrocardiograph and for a very generous supply of nose and throat instruments. Selection of these is now in the hands of the instrument committee.

CLINICOPATHOLOGICAL CONFERENCE

concluded from page 372

has the identical histology of the lung tumor. This is a microscopic tumor. It occupies much less than a single, low-powered field.

I told you there was a tumor 4 c.m. in diameter, in the adrenal gland. You see it here. You see the large cells with abundant cytoplasm and vesicular nuclei. This is the typical histology of a well-known tumor that has various names paraganglioma, chromaffin tumor, or pheochromocytoma. It is quite distinct from the lung tumor.

So that he has two distinct neoplasms.

Here is the section of gut and here is the mucosa [indicating on slides]. In the underlying tissues there are large endothelial lined spaces. They contain albuminous precipitate. This is lymphangioma of the intestine.

The man had three distinct neoplasms.

1. Bronchiogenic carcinoma
2. Pheochromocytoma of adrenal gland
3. Lymphangioma of intestine

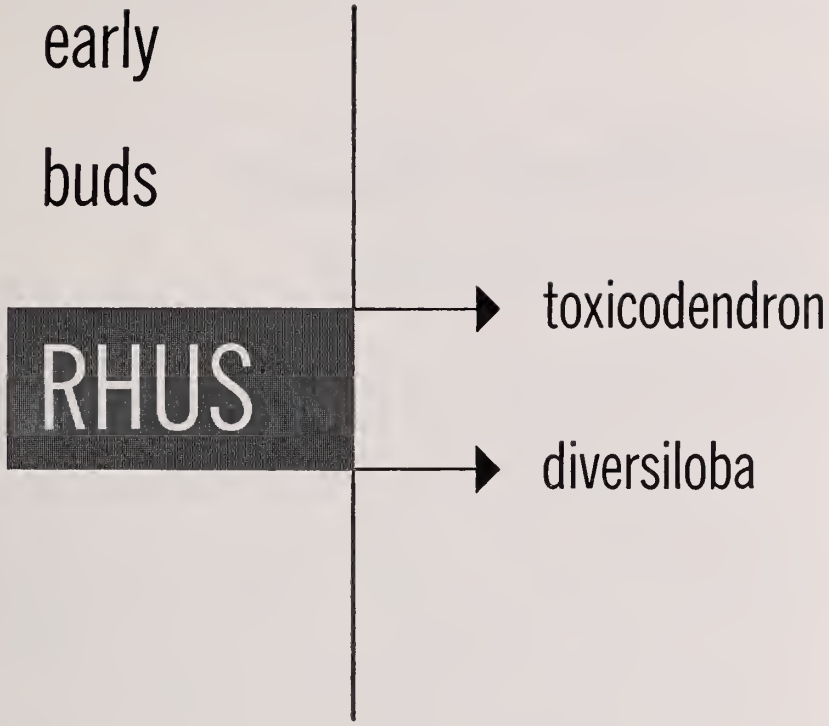
So the man had multiple lesions. It seems to me his renal lesion explains the long-standing history of high blood pressure. These adrenal tumors do sometimes elaborate adrenalin, associated with hypertension, but not always. Usually, when so associated, paroxysms occur. Dr. Sharp suggested a terminal episode. Whether or not you can associate that with the adrenal tumor, I am not certain. It is a possibility.

The renal lesion, I think, would be sufficient to account for the long standing high blood pressure. His more recent history and findings are largely to be explained by the carcinoma of the lung, with extensions to various structures, the vena cava being the most unusual.

DR. FULTON: Was this tumor in the right lung, with metastases in the left, or was it direct extension?

DR. CLARK: Metastases to the left; direct extension of the mediastinum.


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Among the earliest spring buds and foliage are those of poison ivy and poison oak. Immunity to these two pests is never absolute. Anyone may be susceptible, and fifty percent of all contacts are. • In the majority of instances, ivy or oak poisoning may be minimized by prophylactic inoculation with 'Ivyol' Poison Ivy Extract*. • This efficient preparation contains the purified principle of poison ivy (1:1000) in sterile olive oil. Administration by intramuscular injection is relatively painless because of the bland character of the vehicle employed. • 'Ivyol' is supplied in packages containing one or four 0.5-cc. vials, each vial representing a single dose. Sharp & Dohme, Philadelphia 1, Pa.

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When Nitrogen Balance Must Be Restored

In the correction of protein insufficiency, or in the maintenance of nitrogen balance, accumulating evidence substantiates the dictum that hydrolyzed protein substances should be employed *only* when oral feeding of protein foods is impossible or not feasible.

It has been shown experimentally[1] when hydrolysates of protein are injected at two different rates (1.0 and 1.5 mg. of nitrogen per Kg. of body weight per minute), the more rapid injection rate results in a higher excretion of both free amino acids and peptides. The authors ventured that even in the presence of a definite demand for protein replenishment, nitrogen excretion is mainly controlled by the kidney threshold.

In a recent survey, Ravdin[2] stated that "When oral feeding is used, whole foodstuffs should be given. There is no beneficence in feeding protein hydrolysates unless there is evidence of faulty digestion. Feeding of mixtures of polypeptides and amino acids may result in an absorption rate of amino acids which is more rapid than can be resynthesized by the liver, especially when the function of this organ is not normal."

When protein foods are ingested, the contained amino acids are released slowly and in a sustained manner during the course of the digestive processes. The absorptive capacity of the intestinal mucosa is not overtaxed, and maximal amino acid utilization is made possible without urinary loss.

As a source of protein, meat ranks high among the foods of man. It is 96 to 98 per cent digestible, and its protein is biologically adequate, capable of satisfying every protein need of the organism.

1. Editorial: J.Am.Dietet.A., 22:1063 (Dec.) 1946.
2. Ravdin, I.S.: Some Problems of Protein Deficiency, Connecticut M.J., 11:7 (Jan.) 1947.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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AMERICAN MEAT INSTITUTE

MAIN OFFICE, CHICAGO . . MEMBERS THROUGHOUT THE UNITED STATES

REPORT ON METOPON HYDROCHLORIDE

(Statement by Committee on Drug Addiction, Division of Medical Sciences, National Research Council)

METOPON HYDROCHLORIDE
(Methyldihydromorphinone hydrochloride)

In 1929 with the funds provided by the Rockefeller Foundation the National Research Council, through its Committee on Drug Addiction, undertook a coordinated program to study drug addiction and search for a non-addicting analgesic comparable to morphine. The principal participating organizations were the Universities of Virginia and Michigan, the United States Public Health Service, the Treasury Department's Bureau of Narcotics, and the Helath Department of the State of Massachusetts, which brought together chemical, pharmacological and clinical facilities for the purpose of the study. Metopon is one of the many compounds made and studied in this coordinated effort.

Chemically Metopon is a morphine derivative; pharmacologically it is qualitatively like morphine even to the properties of tolerance and addiction liability. Chemically Metopon differs from morphine in three particulars,—one double bond of the phenanthrene nucleus has been reduced by hydrogenation; the alcoholic hydroxyl has been replaced by oxygen; and a new substituent, a methyl group has been attached to the phenanthrene nucleus. Studies made thus far indicate that pharmacologically Metopon differs from morphine quantitatively in all of its important actions,—its analgesic effectiveness is at least double and its duration of action is about equal to that of morphine; it is nearly devoid of emetic action; tolerance to it appears to develop more slowly and to disappear more quickly and physical dependence builds up more slowly than with morphine; therapeutic analgesic doses produce little or no respiratory depression and much less mental dullness than does morphine; and it is relatively highly effective by oral administration.

In addition to animal experiments these differences have been established by extensive employment of the drug in two types of patients,—individuals addicted to morphine, and others (terminal malignancies) needing prolonged pain relief but without previous opiate experience. In morphine addicts, Metopon appears only partially to prevent the impending signs of physical and psychical dependence. In terminal malignancy, administered orally, it gives adequate pain relief, with very little mental dulling, without nausea or vomitting and with slow development of tolerance and dependence.

The high analgesic effectiveness of oral doses (with the elimination of the disadvantage to the patient of hypodermic injection), the absence of nausea and vomiting even in patients who vomit with morphine or other derivatives, the absence of mental dullness and the slow development of tolerance and dependence place Metopon in a class by itself for the treatment of the chronic suffering of malignancies, and it is for that purpose exclusively that it is being manufactured and marketed.

Metopon will be available *only* in capsule form *for oral administration.* The capsules will be put up in bottles of 100 and each capsule will contain 3.0 mgm. of Metopon hydrochloride. They can be obtained by physicians only from Sharp & Dohme or Parke, Davis & Co., on a regular official Narcotic Order Form, which must be accompanied by a signed statement supplying information as to the number of patients to be treated and the diagnosis on each. The drug will be distributed for *no other purpose* than oral administration for chronic pain relief in cancer cases.

The dose of Metopon hydrochloride is 6.0 to 9.0 mgm. (2 or 3 capsules), to be *repeated only on recurrence of pain,* avoiding regular by-the-clock administration. As with morphine, it is most desirable to keep the dose at the lowest level compatible with adequate pain relief. Therefore, administration should be started with two capsules per dose, increasing to three only if the analgesic effect is insufficient.

Tolerance to any narcotic drug develops more rapidly with excessive dosage and under regular by-the-clock administration. Also, as a rule, the pain of cancer varies widely in intensity from time to time. Pain, therefore, should be the only guide to time of administration and dosage level. Tolerance to Metopon hydrochloride develops slowly. It can be delayed or interrupted entirely by withholding the drug occasionally for 12 hours or for as much of that period as the incidence of pain will permit.

continued on next page

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REPORT ON METOPON HYDROCHLORIDE

continued from preceding page

To each physician will be sent a record card for each patient to whom Metopon hydrochloride is to be administered. He will be requested to fill out these cards and return them in the addressed return envelope. He must furnish this record of his patient and his use of Metopon hydrochloride if he wishes to repeat his order of the drug. The principal object of this detailed report is to check the satisfactoriness of Metopon hydrochloride administration in general practice. The physician's cooperation in making it as complete as possible is earnestly solicited.

The limited use of Metopon hydrochloride as described above has been recommended by the Drug Addiction Committee of the National Research Council and the Committee with the cooperation of the American Cancer Society, will supervise the distribution of the drug. The Committee is composed of Wm. Charles White, Chairman, Washington, D. C.; H. J. Anslinger, Commissioner of Narcotics, United States Treasury Department, Washington, D. C.; Lyndon F. Small, National Institute of Health, Washington, D. C.; and Nathan B. Eddy, National Institute of Health, Washington, D. C. Queries and comments on Metopon may be directed to Dr. Eddy, who will answer them for the Committee.

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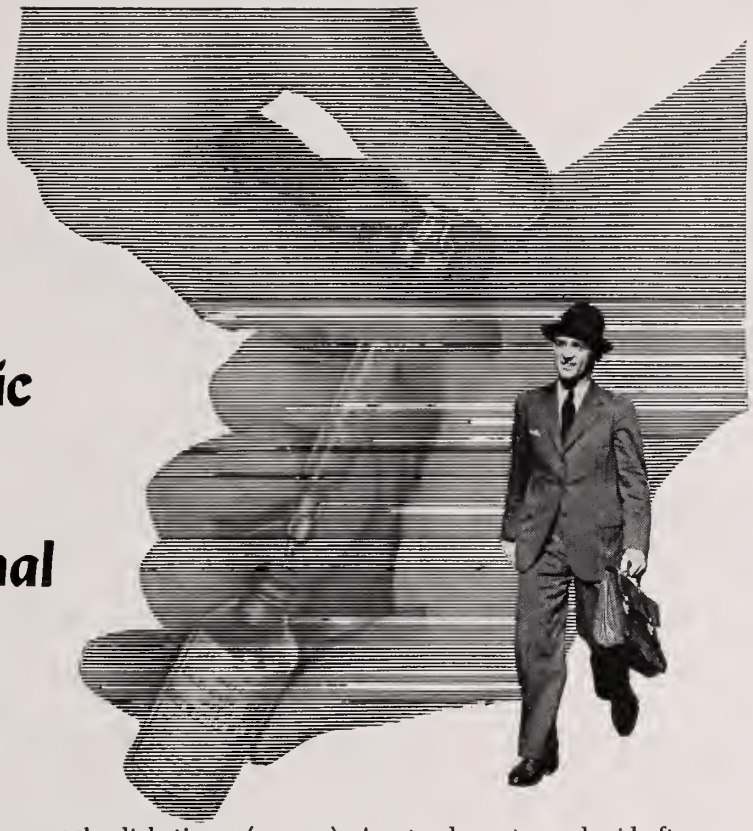
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LIBRARY OPEN NIGHTS

Attention of members is again directed to the fact that the Medical Library is open three evenings each week until the end of June. The evening hours are from 7 to 10 p.m. on Tuesday, Wednesday, and Thursday.



to convert the diabetic into a more normal person

"The ideal in therapy...is to convert the diabetic into a normal person."[1] While certain restrictions must always be imposed, many patients can be controlled through diet alone so as to dislocate their normal habits as little as possible. In those cases where insulin therapy is also required, control may often be attained with but *one daily injection* of 'Wellcome' Globin Insulin with Zinc. Its intermediate action is adaptable to the needs of most mild and many moderately severe cases and adequate control can usually be achieved in three clear-cut steps:

1. *Stabilize the patient* as well as possible on a diet of the desired caloric content. Give a single dose of 15 or 20 units of 'Wellcome' Globin Insulin 30 minutes or more before breakfast.

2. *Adjustment to 24-hour control:* Gradually adjust the Globin Insulin dosage to provide 24-hour control as evidenced by a fasting blood sugar level of less than 150 mgm. or sugar-free urine in the fasting sample.

3. *Adjustment of diet:* Simultaneously adjust the carbohydrate distribution of the diet to balance insulin activity. Initially this may be 2/10 (breakfast), 4/10 (lunch), and 4/10 (supper). Any tendency toward mid-afternoon hypoglycemia may usually be offset by giving 10 to 20 grams of carbohydrate between 3 and 4 p.m. The final adjustment of carbohydrate distribution may be based on fractional urinalyses.

Systematic attention to these details will make possible adequate control of most mild and many moderately severe cases of diabetes with a *single daily injection of 'Wellcome' Globin Insulin with Zinc.*

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties. Available in 40 and 80 units per cc., vials of 10 cc. Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in The Wellcome Research Laboratories, Tuckahoe, New York. U.S. Patent No. 2,161,198. LITERATURE ON REQUEST.

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1. Bauman, L.: Bull. New Eng. M. Center 5:17 (Feb.) 1943.

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WOMAN'S AUXILIARY

TO THE RHODE ISLAND MEDICAL SOCIETY

A MEETING of the Women's Auxiliary to the Rhode Island Medical Society was held on March 31, 1947. Mrs. Herbert E. Harris, President of the Auxiliary, called the meeting to order at 2:00 p. m.

Mrs. Charles L. Farrell, Secretary, read the minutes of the previous meeting, which were approved as read.

Communications were read by the Secretary from officers of the Woman's Auxiliary to the American Medical Association congratulating the Rhode Island Women's Auxiliary on its organization.

Mrs. Harris, the President, announced that the main object of the meeting was to vote on the proposed Constitution and By-Laws, which had been adapted from the model constitution sent out by the Woman's Auxiliary to the American Medical Association for the use of the various state auxiliaries.

The President further stated that the proposed constitution had been reviewed by Mr. John E. Farrell, Executive Secretary of the Rhode Island Medical Society, to obviate any conflict with the Constitution and By-Laws of the Rhode Island Medical Society. It was then studied by the Executive Board of the Woman's Auxiliary and recommended for adoption.

The President then stated that the articles and sections of the Constitution would be read one by one, corrected when necessary, and that the whole Constitution with corrections would be voted upon as a unit at the completion of its reading. The same method would be used for the adoption of the By-Laws.

The Secretary read the proposed Constitution and By-Laws of the Woman's Auxiliary to the Rhode Island Medical Society, pausing after each section, for discussion and correction.

Article IV—Section II was changed to read as follows: "Active members of this Auxiliary shall be restricted to wives of members or widows of deceased members of the Rhode Island Medical Society." The members of the Auxiliary signified by a show of hands that they approved this amendment.

After the Secretary read Article V—Section 1A, discussion ensued about the word "convention". Many members expressed the thought that the words "or annual meeting" should be added. The motion was made and seconded that this section should read as follows: "The legislative powers of this Auxiliary shall reside in the convention or annual meeting." This motion was adopted by a show of hands.

Mrs. Robert M. Lord made a motion that Article IV, Section V, be deleted from the Constitution. Mrs. Ciro Scotti seconded this motion. The President asked for a show of hands and then declared the motion defeated.

Mrs. Leo Cohen moved that Article IV, Section V, be amended to read as follows: "No active member of the Rhode Island Medical Society shall be eligible to active or associate membership in this Auxiliary". Mrs. Herman Winkler seconded the motion. On a show of hands the President declared the motion defeated.

There was a lengthy discussion on Article V, Section III. Mrs. Francis Hanley moved that this section remain as written. The motion was seconded by Mrs. Thomas Dolan. The show of hands was counted and the President declared the motion carried by a large majority.

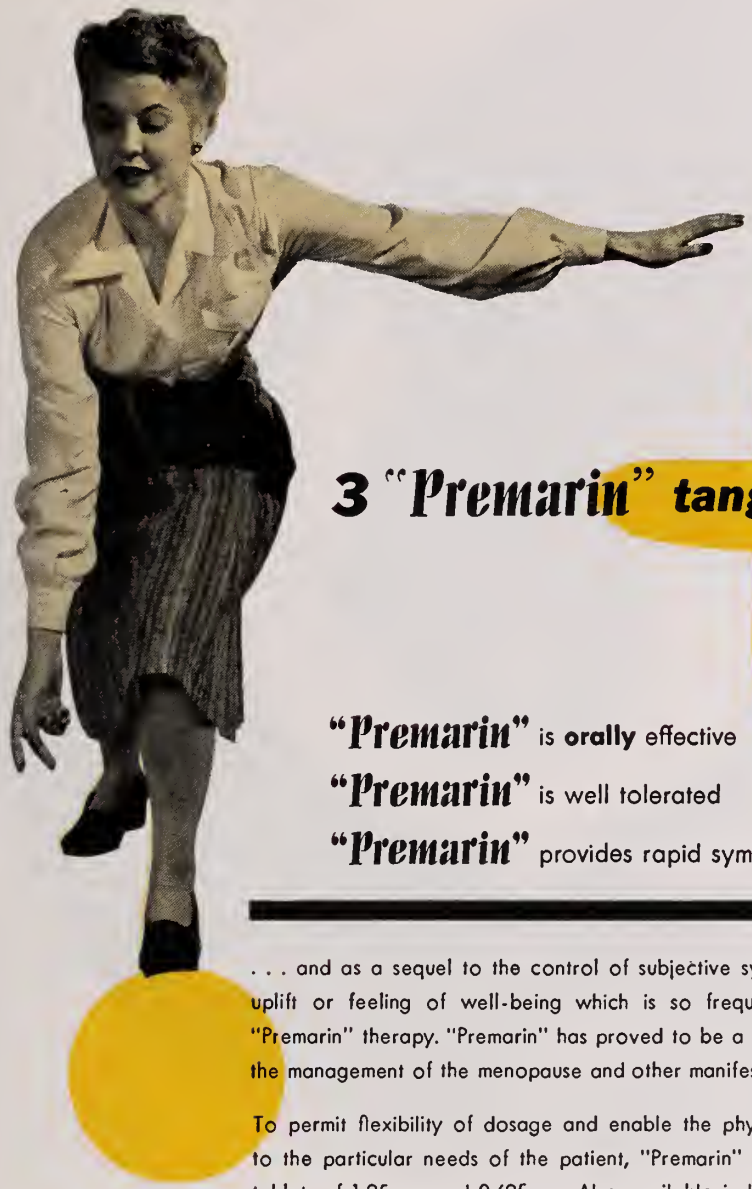
It was the unanimous opinion of the members present that the Treasurer should have until April 21, 1947 to submit to the Secretary a list of members whose dues are paid.

After the Secretary had finished reading the Constitution and the sections had been discussed, the President asked for those in favor of adopting the Constitution as written with correction to raise their right hand. She then declared the motion adopted by a majority vote.

There was a brief discussion on the subject of whether the Woman's Auxiliary should appoint a corresponding secretary in addition to the other officers. The President stated that she thought there was no need for a corresponding secretary as the Executive Office of the Medical Society would supply any needed assistance.

The Secretary then proceeded to read the By-Laws. There was no discussion until Chapter VI, Section IV, regarding dues was reached. The President explained the projected use of income from dues and asked the opinion of the members regarding a three dollar annual assessment. It was

continued on page 391



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WOMAN'S AUXILIARY

continued from page 388

the opinion of the majority that a three dollar dues was satisfactory.

When the Secretary finished reading the By-Laws, Mrs. Lewis Porter asked if it was correct to vote on the Constitution and By-Laws after one reading. The President replied that the Board of Directors had reviewed the Constitution and By-Laws very thoroughly at their last meeting and recommended their adoption. Mrs. Joseph C. Johnston moved that the By-Laws be accepted as read. The motion was seconded by Mrs. H. Lorenzo Emidy and the President declared it unanimously adopted.

Mrs. Henry S. Joyce moved that the Board of Directors elected at the organization meeting of the Woman's Auxiliary be instructed to present as its slate of candidates the temporary officers of the Auxiliary and its present temporary Board of Directors. There was no objection to this motion which was seconded by Mrs. Joseph C. Johnston. The President declared the motion unanimously adopted. The President then reminded the members that counter nominations may be presented at the convention.

There was some discussion regarding a date for the annual luncheon meeting the first week of May. The President stated that she hoped to obtain a speaker from the national organization for that event. Mrs. Joseph C. Johnston moved that the convention or annual meeting be held during the first week of May. The motion was seconded by Mrs. Henry S. Joyce and the President declared it unanimously adopted.

Mrs. William Roberts moved that Mrs. Roland Hammond be appointed Chairman of Arrangements for the convention. Mrs. Robert T. Henry seconded the motion and the President declared it unanimously adopted.

The meeting adjourned at 4:00 p. m.

Respectfully submitted,

MRS. CHARLES L. FARRELL,
Secretary

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FOR ABDOMEN, BACK AND BREASTS

GROUP PRACTICE IN A SMALL COMMUNITY*

R. F. DeWitt, M.D.

The Author. *R. F. DeWitt, M.D., of Plymouth, N. H. Member, The Associated Medical Center of Plymouth and Ashland, New Hampshire.*

As a member of the Associated Medical Center of Plymouth and Ashland, New Hampshire, it is my privilege to present our group for consideration as one method designed to improve rural medicine. To the best of my knowledge we are the smallest group practicing in the smallest community of any of the four groups of the state of New Hampshire.

We are located in a community of about three thousand people with a rather large outside drawing from the neighboring towns. Although basically rural, we do have considerable industrial and resort practice. There are three other practicing physicians in the community in addition to the members of the Associated Medical Center which is made up of Dr. Feiner, Middleton, Orton, and myself. The one, inadequate thirty-bed hospital serves members of the group and non-members of the group.

To understand a little of the development of the group let us look back at the history a bit. The community is unique in that about fifteen years ago there was a very rapid change in medical care from the older doctors who either died or moved away within about a two year period, and the resulting influx of a group of young doctors to take their places. There was no organized, and as far as is known to me, never had been, an organized hospital staff. Although some active surgery was done, veneclysis and transfusions were few and assumed rather major proportions at that time. There was and had been a constant disagreement and jealousy among the older doctors. This was the heritage of us younger men. Within the next three years we had broken down the old prejudices and formed a hospital staff composed of those physicians who were in active practice in the community at that time. It was at one of these hospital staff meetings that the idea of group practice was proposed and on January 1, 1942 the partnership known as the Associated Medical Center was born.

* Presented at the Second Annual Meeting, Council of the New England State Medical Societies, at Boston, April 16, 1947.

The purpose as quoted from our partnership agreement is "the practice of medicine and surgery together under partnership direction, each associate to retain his individual practice and responsibility to his respective patients; but aiming by the combination of their abilities, skill, energy, capital, and equipment to serve their patients better and to provide superior skill, equipment, and application of the results of the latest research accepted, approved, and adopted by the best authorities in the profession, and in accord with the accepted ethical standards of the reputable state and national medical-surgical societies and associations."

To ourselves we have provided a method whereby we have an opportunity to spend time for study and vacation.

This method of practice assures us of an increase in individual knowledge and by our close association greatly multiplies the knowledge of the entire group.

As a result we have been able to provide for the community both knowledge and equipment which it was impossible for the community to obtain without traveling long distances. To elucidate a bit we have provided, in addition to general medicine and surgery, more detailed work in cardiology, allergy, orthopedics, obstetrics, gynecology and urology. By the continued efforts of the group it is our impression that our practice of medicine must as a result compare favorably with other communities of similar size.

It is always a question in the minds of those not familiar with the economy of group practice, as to how we provide for the individual income. To my knowledge there are as many ways as there are groups. I am not familiar with any method that does not have at least one drawback. With us we have found it quite satisfactory to use the following general plan. At the time we started, a basic salary was agreed upon for each partner based upon his previous income tax returns. Any balance left in the treasury at the end of the year is divided according to the percentage of contribution to the treasury. All receipts from the practice of medicine are turned into the treasury.

We feel that more men, particularly in specialty work, should be added to the group. As you can

continued on page 396

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MEDICAL GROUPS IN THE UNITED STATES, 1946

G. HALSEY HUNT, M.D.
Senior Surgeon, U. S. Public Health Service

THE U. S. Public Health Services is currently conducting a study of medical group practice in the United States, in an effort to assemble factual information about this subject.

Early in the course of the study it became evident that little information was available as to the existence, location, and size of groups. Lists of groups were obtained from the American Medical Association, Medical Administration Service, Inc., and the National Association of Clinic Managers, but no list carried up to date information (if any) about these points.

In the summer of 1946 a mail questionnaire was sent to all of the groups appearing on any of these lists, as well as to the organizations listed in "Prepayment Medical Care Organizations." A high percentage of the questionnaires was returned, and a statistical summary of the findings will be published elsewhere.

In addition, it has seemed advisable to publish a directory of the groups about which information is available as a result of the questionnaire. This directory must be looked upon as tentative and incomplete, since some groups did not appear on any of the source lists, and some known groups did not return the questionnaire, but there is evidence that the great majority of existing groups are included. It is hoped that publication of this directory will stimulate the flow of information about groups which are omitted from this listing.

Because of the lack of an accepted definition of what constitutes a group, it was thought wise to be as inclusive as possible in this listing. The only qualifications required of a group for inclusion here, therefore, are, first, that it have some sort of formal organization, and second, that it have at least three full-time physician members.

The groups listed for New England in this directory are as follows:

MASSACHUSETTS

HOLDEN CLINIC Private
8 Boyden Road, Holden, Mass.
Medical Director: Dr. Edward J. Crane
Business Manager: Mr. Walter J. Snow
Primary Activity: General medical care. Fields covered: Multiple
Number of Physicians: Full time—4; Part time—0. Number of Dentists: 0
Date of information: 8/3/46

FALLON CLINIC Private
10 Institute Road, Worcester 2, Mass.
Medical Director: Dr. John Fallon
Business Manager: Mr. E. Clancy
Primary Activity: Referred work. Fields covered: Multiple
Number of Physicians: Full time—5; Part time—3. Number of Dentists: 0
Date of information: 7/10/46

NEW HAMPSHIRE

THE CLINIC & CLINIC HOSPITAL Private
27 Green Square, Berlin, N. H.
Medical Director: Dr. Burton S. Munro
Business Manager: Dr. Burton S. Munro
Primary Activity: General medical care. Fields covered: Multiple
Number of Physicians: Full time—4; Part time—1. Number of Dentists: 0
Date of information: 7/11/46

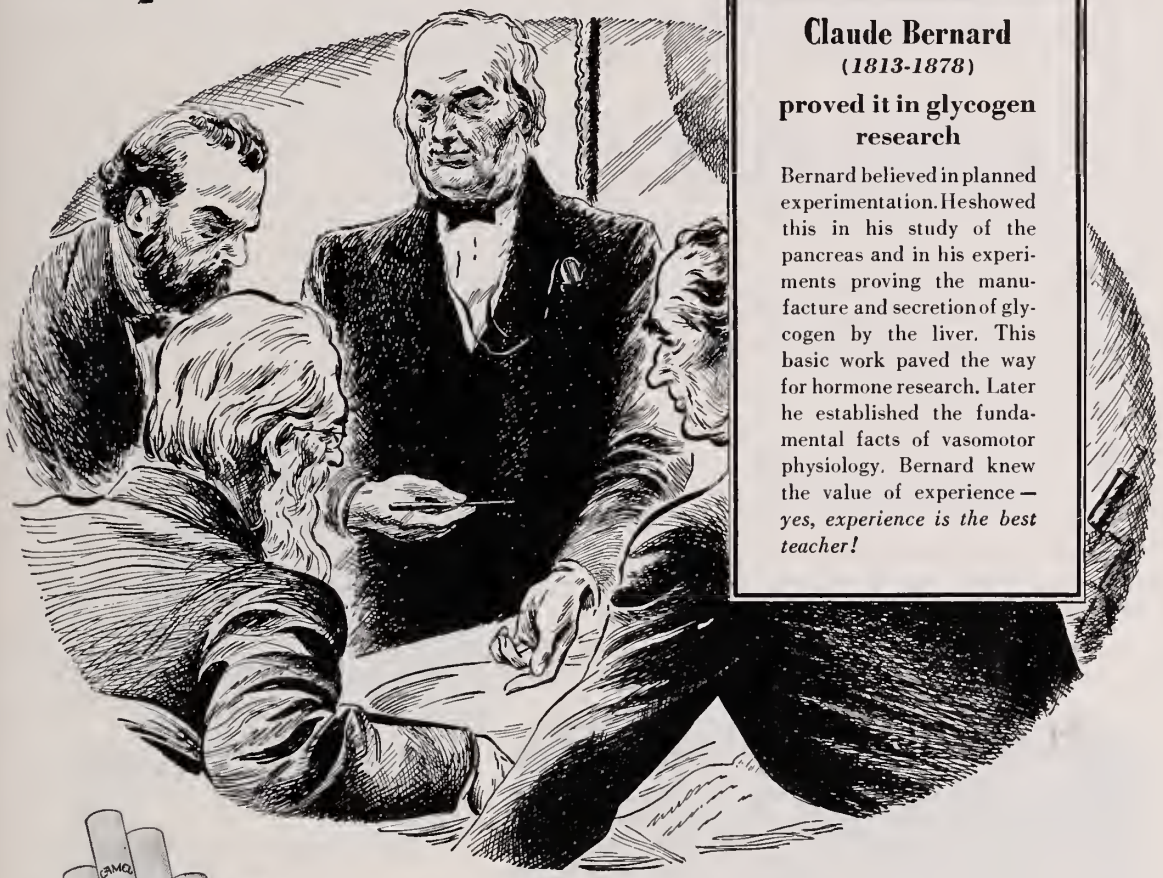
HITCHCOCK CLINIC Private
Hanover, N. H.
Medical Director: Dr. John P. Bowler
Business Manager: None
Primary Activity: Referred work. Fields covered: Multiple
Number of Physicians: Full time—25; Part time—1. Number of Dentists: 0
Date of information: 7/26/46

THE LACONIA CLINIC Private
724 Main St., Laconia, N. H.
Medical Director: Dr. Chester L. Smart
Business Manager: None
Primary Activity: General medical care. Fields covered: Multiple
Number of Physicians: Full time—10; Part time—0. Number of Dentists: 1
Date of information: 7/9/46

THE ASSOCIATED MEDICAL CENTER Private
Main St., Plymouth, N. H.
Medical Director: None
Business Manager:
Primary Activity: General medical care. Fields covered: Multiple
Number of Physicians: Full time—4; Part time—0. Number of Dentists: 0
Date of information: 8/20/46

continued on page 396

Experience is the Best Teacher



Claude Bernard
(1813-1878)
proved it in glycogen research

Bernard believed in planned experimentation. He showed this in his study of the pancreas and in his experiments proving the manufacture and secretion of glycogen by the liver. This basic work paved the way for hormone research. Later he established the fundamental facts of vasomotor physiology. Bernard knew the value of experience — *yes, experience is the best teacher!*



Yes, and experience is the best teacher in smoking too!

THAT wartime cigarette shortage was a real experience to smokers. Millions of people smoked more different brands than they would normally try in a lifetime. And out of the comparisons of that experience so many more smokers came to prefer Camels that today more people are smoking Camels than ever before.

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than any other cigarette

R. J. Reynolds Tobacco Co., Winston-Salem, N. C.

GROUP PRACTICE IN A SMALL COMMUNITY

concluded from page 392

well understand, this has been an uphill procedure during the past war years.

We sincerely believe that we have, through these years, so improved medicine in our rural community that there is no comparison between the years gone by and the present time. By our close relationship and continued effort we will be able to maintain a high standard of medicine and surgery and not become content to rely on our past laurels.

Another point that has been questioned many times concerns our work with the practitioner outside of the partnership. This we have been able to do on an amiable and cooperative basis attempting to render whatever assistance we may be called upon to give.

At present our group may not have all of the answers to the practice of group medicine now or for medicine to come, but it has proven to us to be far superior to anything we have experienced before in private practice.

I have attempted to give the highlights of our little group. There undoubtedly may be left questions which have not occurred to me. I, as far as I am able, will be only too happy to give my impressions on the new and growing brand of medicine which has so many possibilities both good and bad depending upon the integrity of those who practice it.

MEDICAL GROUPS IN THE U.S.

concluded from page 394

VERMONT

FITCH CLINIC Private
122 Railroad St., St. Johnsbury, Vermont
Medical Director: Dr. D. E. Coburn
Business Manager: None
Primary Activity: General medical care. Fields covered: Multiple
Number of Physicians: Full time—6; Part time—2. Number of Dentists: 0
Date of information: 7/12/46

WINDSOR MEDICAL & DENTAL GROUP Private
Windsor, Vermont
Medical Director: None
Business Manager: Dr. William H. Krause
Primary Activity: General medical care. Fields covered: Multiple
Number of Physicians: Full time—3; Part time—0. Number of Dentists: 1
Date of information: 8/1/46

(NOTE: *The above abstract is from a study released by the Federal Security Agency, U. S. Public Health Service, Division of Public Health Methods, in February, 1947.)*

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* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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BOOK REVIEW

Allergy in Theory and Practice by Robert A. Cooke, et al. W. B. Saunders Company, Philadelphia, 1947. $8.00

This book of Dr. Cooke's is the best book on allergy for the practitioner at the present time. The practical points in diagnosis and treatment are well presented with the scientific background which Dr. Cooke has done such a large part in developing. Although it lacks some of the detail contained in the larger books previously published, notably that of Vaughan, this reviewer thinks that it makes up for its small size by clarity and conciseness.

It is unfortunate that allergists cannot agree on a method of standardizing treatment extracts. Dr. Cooke uses protein nitrogen units in measuring his doses which makes added difficulty for most of his readers.

The lack of material on the allergies of infancy and early childhood is deplorable. This is the fault of the pediatricians for not having developed the knowledge in this field.

WILLIAM P. BUFFUM, M.D.

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MEDICAL LIBRARY NOTES

NEW MEDICAL BOOKS AVAILABLE

The Librarian of the Rhode Island Medical Society Library announces the recent addition of the following books:

DAVENPORT COLLECTION

Willard Marmelszadt—Musical Sons of Aesculapius. N. Y., 1946.

ACETANILID

Martin Gross—Acetanilid. A Critical Bibliographic Review. New Haven, 1946.

ALLERGY

Robert A. Cooke—Allergy in Theory and Practice. Phil., 1947.

ANATOMY

Henry Gray—Anatomy of the Human Body. Edited by Warren H. Lewis. 24th ed. rev. Phil., repr. 1946.

ANESTHESIA

The Centennial of Surgical Anesthesia. An Annotated Catalogue. Compiled by John F. Fulton & Madeline E. Stanton. N. Y., 1946.

DERMATOLOGY

George C. Andrews—Diseases of the Skin. 3rd ed. Phil., 1946.

George M. MacKee & Anthony C. Cipollaro — X-rays and Radium in the Treatment of Diseases of the Skin. 4th ed. Phil., 1946.

DIABETES

Elliott P. Joslin & others — The treatment of Diabetes Mellitus. 8th ed. Phil., 1946.

ELECTROCARDIOGRAPHY

Ashton Graybiel & Paul D. White — Electrocardiography in Practice. 2nd ed. Phil., 1946.

FOLIC ACID

Tom D. Spies—Experiences with Folic Acid. Chic., 1947.

GASTROENTEROLOGY

Henry L. Bockus—Gastro-enterology. Vol. III & index. Phil., 1946.

MEDICAL ECONOMICS

Nathan Sinai & others—Health Insurance in the United States. N. Y., 1946.

Bernhard J. Stern—Medical Services by Government. Local, State and Federal. N. Y., 1946.

MEDICINE

George F. Dick & others, editors—The 1946 Year Book of General Medicine. Chic., 1946.

NEUROLOGY

H. Houston Merritt & others—Fundamentals of Clinical Neurology. Phil., 1947.

ORTHOPEDICS

John A. Key & H. Earle Conwell—The Management of Fractures, Dislocations, and Sprains. 4th ed. St. L., 1946.

PATHOLOGY

William A. D. Anderson—Synopsis of Pathology. 2nd ed. St. L., 1946.

POLIOMYELITIS

Collected Reprints of the Grantees of the National Foundation for Infantile Paralysis. Vol. VI, 1945. N. Y.

SURGERY

Evarts A. Graham, editor—The 1946 Year Book of General Surgery. Chic., 1947.

VASCULAR DISEASES

Edgar V. Allen & others—Peripheral Vascular Diseases. Phil., 1946.

WAR MEDICINE

Roy R. Grinker & John P. Spiegel—Men Under Stress. Phil., 1945.

MISCELLANEOUS

The Pharmacopoeia of the United States of America. 13th revision. Easton, 1947.

Directory of Medical Specialists. Vol. III. Chic., 1946.

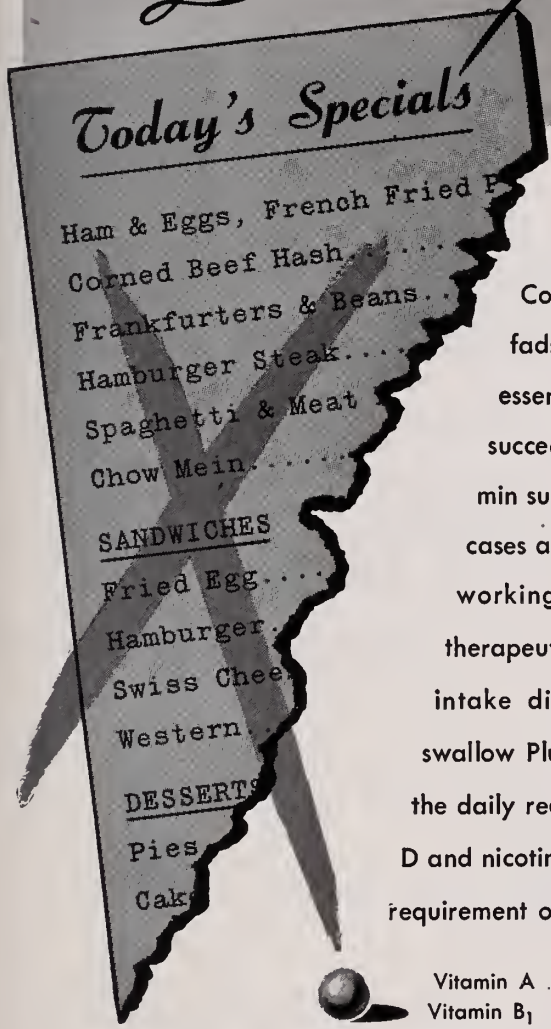
Transactions of the American Proctologic Society. 45th. San Fran., 1947.

Transactions of the Association of American Physicians. Vol. LIX. Phil., 1946.

GIFTS

Gifts of books, journals and pamphlets were received from the following: Doctors Frank M. Adams, Irving A. Beck, Francis V. Corrigan, Morgan Cutts, Halsey DeWolf, Roland Hammond, Louis I Kramer, Albert L. Lagerquist, Jesse E. Mowry, and Stephen A. Welch and from Brown University, the Ethicon Suture Laboratories, the Providence Lying-In Hospital, the Providence Public Library and the U. S. Government.

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BROADCAST . . . MAY 24

Members are urged to listen to the AMA Centennial radio broadcast on Saturday, May 31 from 4:00-4:30 p. m. over the stations of the NBC. (WJAR—WBZ-WBZA—WTIC in this area)

The May 24 program will feature a dramatization of the life of Oliver Wendell Holmes, and a three men talk by Dr. James R. Miller of Hartford, presently a trustee of the AMA, on medicine of today in Southern New England.



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CHARLES V. CHAPIN ORATION

"The Control of Typhus Fever"

See Page 423

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Volume XXX, No. 6

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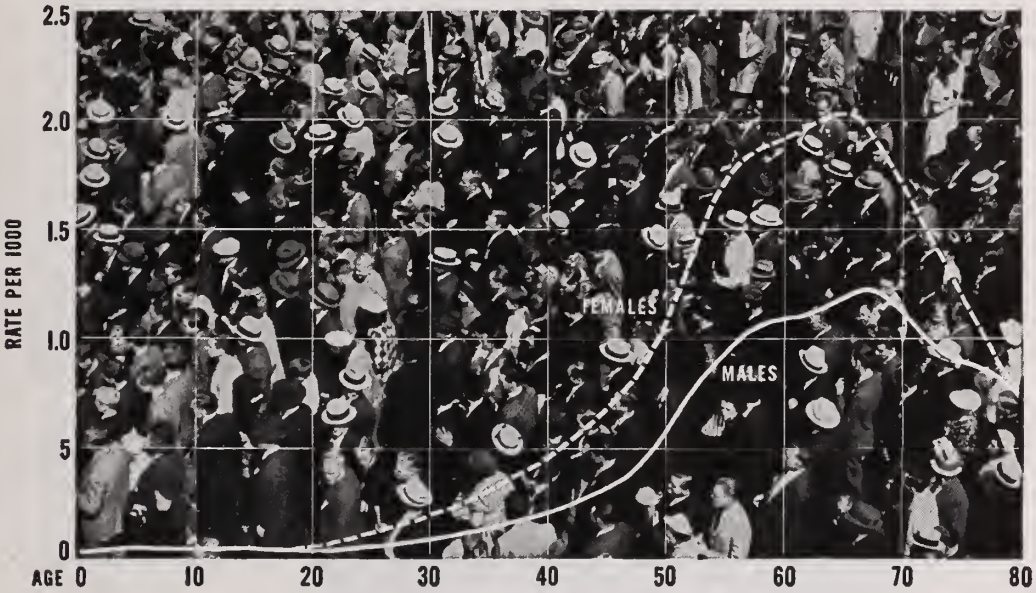
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1. Spiegelman, M., and Marks, H. H.: Am. J. Pub. Health 36:26 (Jan.) 1946. 2. Statistical Bull., Met. Life Ins. Co. 27:6 (Feb.) 1946.

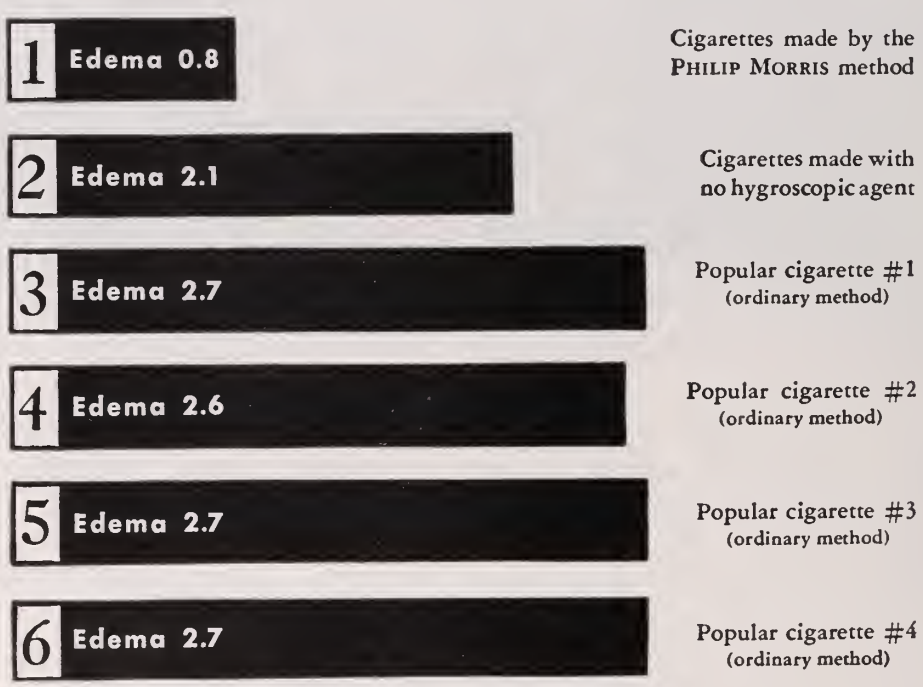
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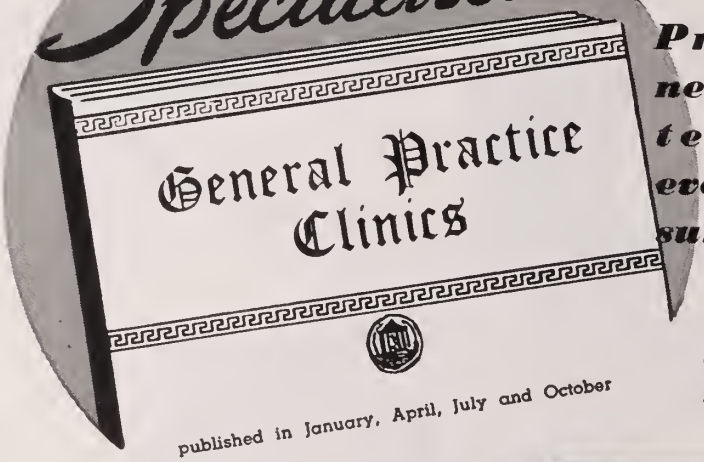
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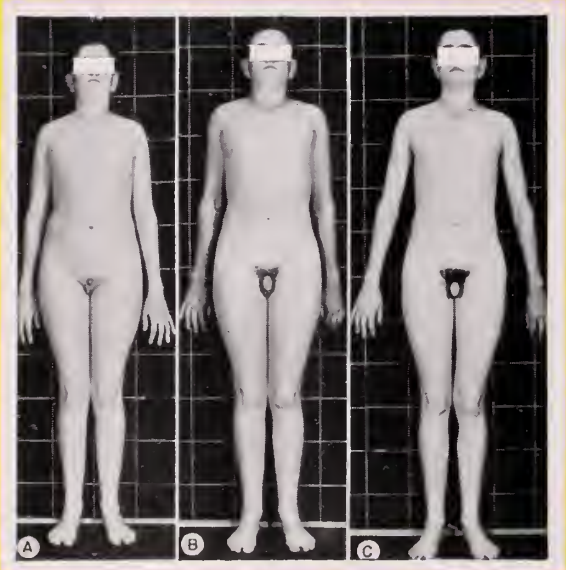
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1. Lisser, H., and Curtis, L. E.: Jl. Clin. Endo., 3: 389 (July), 1943.



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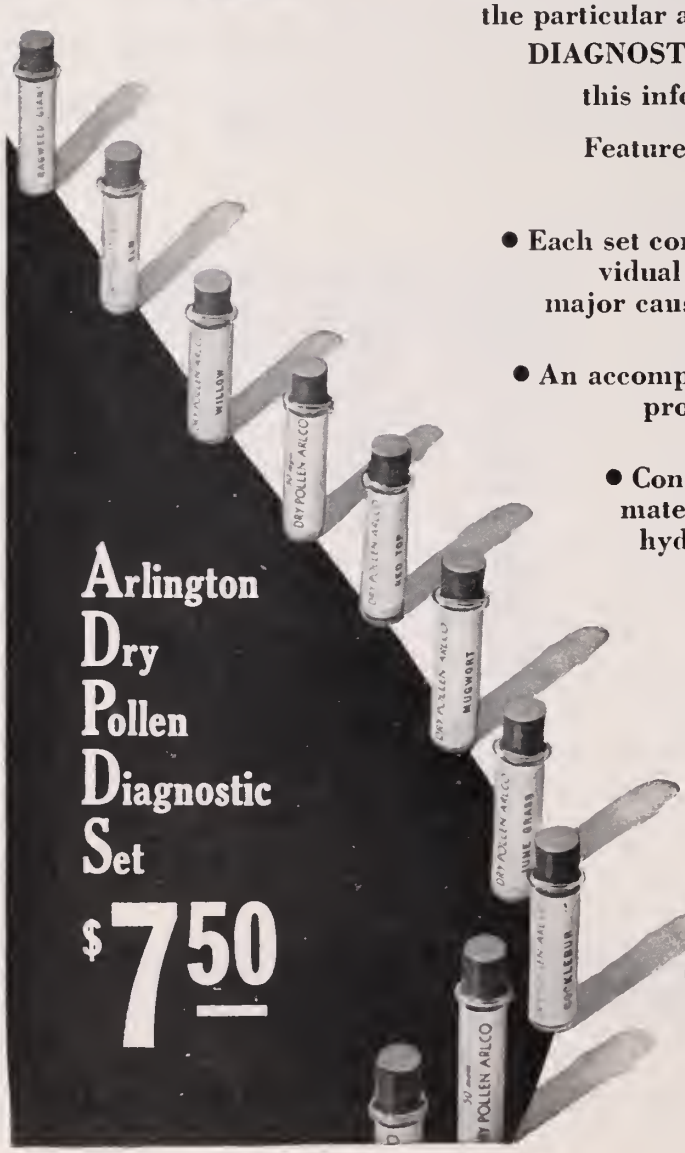
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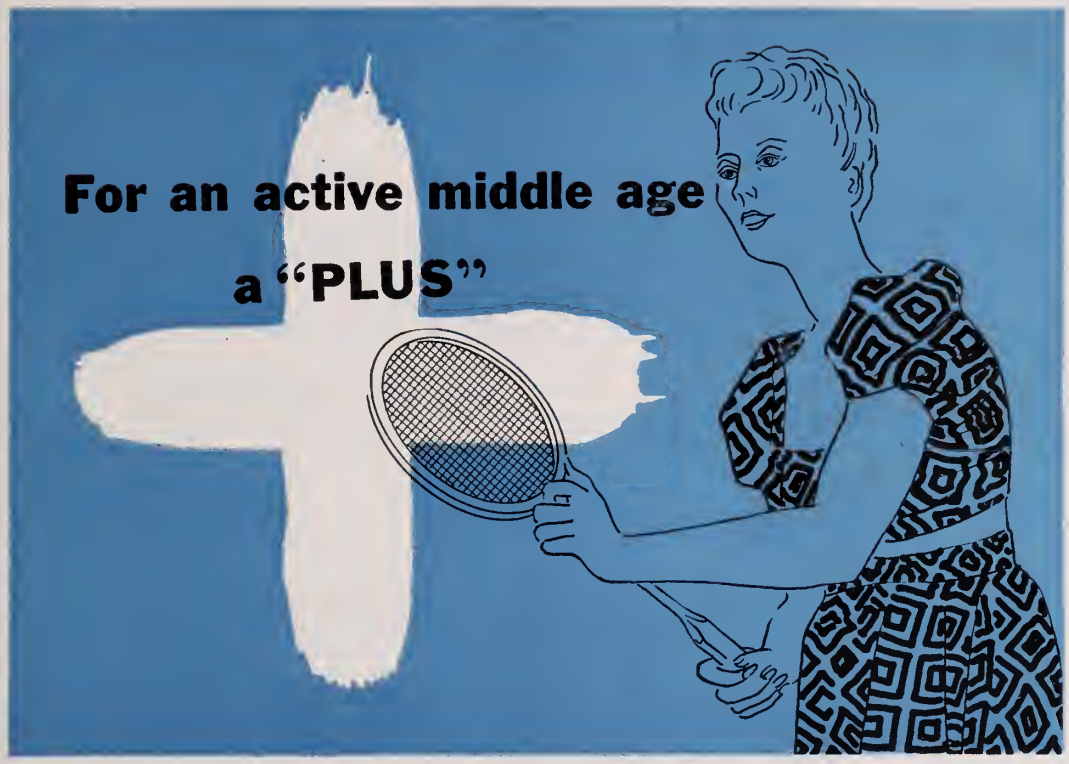
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The Sixth Annual Charles V. Chapin Oration

THE CONTROL OF TYPHUS FEVER*

STANHOPE BAYNE-JONES, M.D.

The Author. *Stanhope Bayne-Jones, M.D., of New Haven, Conn.; Professor of Bacteriology, Yale University School of Medicine; Brigadier General, Medical Corps, Reserve; Formerly Deputy Chief, Preventive Medicine Service, Office of The Surgeon General, U. S. Army, and Director, United States of America Typhus Commission; President, Army Epidemiological Board.*

IN SELECTING me to present the Charles Value Chapin Oration, the Rhode Island Medical Society has done me great honor and admitted me to cherished privileges. This distinction has come to me, I realize, not for original contributions to preventive medicine and public health, but through the association I have had the good fortune to enjoy with some of the leaders in public health administration and investigators of infectious diseases. I feel that I have accepted the honor in the names of these men and of the military and civilian groups which were effective teams of the type fostered by Doctor Chapin. It has been their purpose, as it was his, to get at the facts of situations, determine the best relevant scientific information, attack unsolved problems, and apply accurate information for the public welfare. These have been concerted activities of operative epidemiology. The privileges to which you have admitted me have been more personal. The occasion has renewed associations with friends in this distinguished Society. Furthermore, in preparing for this oration I have read a number of the papers by Doctor Chapin and accounts of his life and service. This has brought me into contact with the spirit of a great man.

When I told your officers that I should like to talk about typhus control, one of them expressed uncertainty as to the appropriateness of the topic as it might seem too remote or exotic for this audience. As you are not troubled with typhus in Rhode Island, that may be so. Louse-borne epidemic typhus has not been a serious problem in New England since early in the last century, and it is unlikely that it will be a problem in a community such as yours which has the intelligence, knowledge and means to prevent the spread of the disease. In these days of airplane travel, however, a case of louse-borne typhus might occur even in Providence in some passenger whisked by air from a typhus area abroad during the incubation period of the disease. Such things have occurred in recent years in several places in the United States. Imported laborers from a country where typhus is endemic have been known to introduce the disease into states in which it had not occurred previously. There may be peculiar latent infections in rodents or human beings that are the residues of earlier importations of one form of typhus or another[2, 43]. Although rare, these are of interest. Occasionally, flea-borne or murine typhus has occurred in New England. In Massachusetts and Rhode Island no distinction is made between Brill's disease and murine typhus. It is not possible to tell, therefore, how many of the few reported cases of "endemic typhus" were Brill's disease, now regarded by many as epidemic typhus from the work of Zinsser and Plotz[43, 26]. Tick-borne spotted fever, of the Rocky Mountain spotted fever group, occurs near enough to Rhode Island to warrant maintenance of an alert for cases. Other rickettsial infections are not remote. Q fever[13, 36] has been seen as an importation, but not as a spreading disease, in these parts, and the newly recognized mite-borne rickettsial pox[21, 22] of last year's outbreak in one of the five burroughs of New York City, is of direct interest

continued on next page

* Presented at the 136th Annual Meeting of the Rhode Island Medical Society, at Providence, on May 14, 1947.

to physicians and public health officers of Rhode Island.

In many ways Rhode Island, although free from typhus, has common interests with the rest of the world in the investigation and control of all the rickettsial diseases[17]. Information gained from the study of the intracellular rickettsiae sheds light on similar organisms and their activities in other diseases. The development of insecticides against lice, fleas, ticks and mites because they transmit rickettsial infections becomes of practical value in many other situations in places where these diseases rarely, if ever, occur. Rodent control devised to reduce murine typhus in the South has possibilities for saving losses of lives and produce in New England when applied for other reasons. Chemotherapy of typhus fevers contains promises for advance in the treatment of other diseases[18, 34, 40]. There is a oneness and continuity in all biological work of this type, as there is a oneness of the world united by necessity in defense against enemies which menace health.

Epidemic typhus which through the centuries has been a hindrance to military operations and a devastating calamity for populations afflicted by war and shortages of food and the means for keeping free of vermin, united many interests for the defense of our country, the winning of World War II and the safeguarding of occupied regions. Not one but several forms of typhus fevers became of first rank importance to this nation. In the preservation of the health of soldiers, who were both our kinfolk and our representatives, typhus control was important to every home from which these men came. All may take pride and satisfaction in the achievements along these lines which make a brilliant chapter in military preventive medicine and contribute directly to national and international public health.

In general, the account of typhus control has an appeal as a good story. With the exception of Q fever, the rickettsial diseases are transmitted by insects, various anthropods, such as lice, fleas, ticks, and mites. Doctor Chapin,[10] who in his essay in 1885 on "The Present State of the Germ Theory of Disease" was one of the first in this country to realize and accept the importance of Pasteur's discoveries, was interested both in the spread of disease by contact and its transmission by insects. I found little or nothing about typhus in his papers that I examined, but did find several evidences that the exotic aroused his interest. In his paper in 1927[11] on "The Principles of Epidemiology," speaking of disease transmitted by insects, he wrote: "The development of our knowledge of these diseases furnishes the most fascinating chapter in medical history."

A part of the modern chapter on the control of typhus fevers will be presented here. The material for it has been drawn from so many sources that detailed acknowledgment of all of them will not be attempted. A few selected references are appended.

Rickettsial Diseases of Man

The rickettsial diseases of man are caused by small microorganisms which occupy a position somewhere between the bacteria and viruses. In man and animals these organisms usually occur within the cells of endothelial lining of blood vessels. They have not been cultivated outside of the presence of living cells. Nearly all are transmitted by insects (various arthropods), and some have reservoirs in the lower animals such as rats, rabbits and dogs. Their cycles of growth and transmission are complicated and are not fully known in all instances. As the cycles of growth and transmission of the more important rickettsial diseases of man involve a stage in insects they are particularly vulnerable to attack directed against the insect vectors. Such vectors and reservoirs can be destroyed. Hence control measures are largely based upon eradication, destruction, or control of the insect transmitters of these diseases. It is well to recall here that modern work along these lines is not yet forty years old. It stems from two fundamental discoveries made in 1909. In that year Howard Taylor Ricketts,[28, 29] of the University of Chicago, discovered the organism causing typhus fever. In his honor the genus was named *Rickettsia*. In the same year, Charles Nicolle[25] of the Pasteur Institute of Algiers, proved that typhus fever is transmitted from man to man by the body louse. Ricketts' discovery was the basis of all modern *specific* diagnosis, serum therapy and the prevention and amelioration of typhus by immunization, as well as a vast amount of research. To say this does not belittle the value of knowledge gained from the use of the Weil-Felix agglutination reactions with various types of *Proteus* bacilli. Those reactions have been indispensable for diagnosis and epidemiology. But the explanation of their basis has not yet been provided, and therefore Weil-Felix tests remain outside the field of rickettsial specificity. Nicolle's discovery redirected the attack against the louse vector in epidemic typhus. As Zinsser[42] has said: "The strategic initiative passed into the hands of man, with the discovery in 1909, by Charles Nicolle. The victim was in a position to organize a rationally planned and strategically sound defense against his historic enemy." This defense is chiefly an attack upon the insect vector.

The rickettsial diseases of man, with some selected information about the organisms causing them, the animal reservoirs, insect vectors, modes of transmission and chief control measures may be grouped and summarized in the following table (Table I).

TABLE I

RICKETTSIAL DISEASES OF MAN

Disease	*Causative Organism*	*Animal Reservoir*	*Insect Vector*	*Transmission*	*Control*
I. LOUSE-BORNE: 1. Epidemic, exanthematic typhus	Rickettsia prowazeki	Man	Body louse, Pediculus humanus	By infected louse feces, through the skin, occasionally by inhalation and through conjunctiva.	Louse eradication and prevention, delousing, with insecticides (DDT, etc.), and heat. Vaccination, isolation, quarantine.
2. Trench fever	Rickettsia wolhynica	Man	Body louse	By infected louse feces, through skin.	Louse control
II. FLEA-BORNE: 3. Endemic, murine typhus	Rickettsia prowazeki (Var. typhi, or mooseri)	Rats	Rat fleas, chiefly Xenopsilla cheopis	By infected flea feces, through the skin.	Rodent control, and flea control, use of insecticide (DDT) in rat burrows, etc., vaccination.
III. TICK-BORNE: 4. Rocky Mountain spotted fever, in U. S. A. Western type Eastern type	Dermacentroxenus rickettsi rickettsi rickettsi	Rodents rabbits, dogs rabbits, dogs rabbits, dogs	Ticks, chiefly Dermacentor amblyoma Dermacentor variabilis and Rhipicephalus sanguineus	By tick bite By tick bite By tick bite	Avoidance of infected areas, control of rabbits and dogs, removal of ticks, tick control by insecticides (developing), vaccination.
5. South American spotted fever	Rickettsia sp.?	Dogs, rodents, opossum (?)	Amblyoma cajannense	By tick bite	
6. South African tick typhus	Rickettsia sp.	Rodents and dogs?	Rhipicephalus evertsi	By tick bite	
7. Siberian tick typhus	Rickettsia sp.	Rodents	Dermacentor nuttali	By tick bite	
8. Indian tick typhus	Rickettsia sp.	Unknown	Tick sp.?	By tick bite	
9. North Queensland tick typhus	Rickettsia sp.	Unknown	Tick sp.?	By tick bite	
10. Fievre boutonneuse	Rickettsia conori	Dogs		By tick bite	As for spotted fever.
IV. POSSIBLY TICK-BORNE, BUT ALSO CONTAGIOUS: 11. Q fever	Rickettsia burneti	Bandicoot rodents sheep?, man	Possibly various ticks including Dermacentor andersoni and Amblyoma americanum	By tick bite possibly, and by inhalation.	Tick control, and respiratory disease control measures.
V. MITE-BORNE: 12. Scrub typhus, tsutsugamushi disease	Rickettsia tsutsugamushi (=orientalis)	Field voles and field rats	Larval mites, chiefly Trombicula deliensis	By bite of larval mite.	Ground clearance, avoidance of infected areas, use of miticides in clothing; vaccination to be developed.
13. Rickettsial pox	Rickettsia akari	House mice	Larval mite, Alloderma-nissus sanguineus	By bite of larval mite.	Rodent control against mice.

Epidemic Louse-Borne Typhus

When the United States entered the war in 1941, efforts already underway were intensified to devise better methods and to obtain better materials for the prevention and control of typhus fever. In this work numerous federal, military and civilian agencies and many individuals became united in the far-reaching type of collaboration that was characteristic of the allied war effort. The cooperating organizations included the Medical Departments and other divisions of the Army and Navy, the United States Public Health Service, the Department of Agriculture, the National Research Council, the Committee on Medical Research, the Rockefeller Foundation and the research and production divisions of chemical and biological manufacturing firms. Close liaison was maintained with Canadian and British laboratories and organizations concerned with typhus fever and other rickettsial diseases.

The attack on typhus was centralized and strengthened on December 24, 1942 by the establishment of the United States of America Typhus Commission[3] by President Roosevelt's Executive Order No. 9285. The need for a special commission on typhus became apparent from studies of the situation made in the Preventive Medicine Service of the Office of The Surgeon General of the Army in July 1942, when plans for the North African campaign were being discussed. The conception grew with increasing understanding of the extent of the problems and finally by act of the President, the United States of America Typhus Commission was created as a joint enterprise of the Army, Navy and United States Public Health Service under the supervision and direction of the Secretary of War "for the purpose of protecting the members of the armed forces from typhus fever and preventing its introduction into the United States." The Director of the Commission was "authorized and directed to formulate and effectuate a program for the study of typhus fever and the control thereof, both within and without the United States, when it is or may become, a threat to the military population." The establishment of this Commission and the powers conferred upon it constitute a remarkable phase of federal administrative attack upon a single disease, or, as it developed, upon the group of closely related diseases, epidemic typhus, murine typhus, and scrub typhus.

Executive Order No. 9285 placed a medical commission on a high staff level and provided for direct access of the Director of the Commission to the Secretary of War, and, with his sanction, to heads of general staff and service divisions, and to Theater Commanders. The experience of the Commission contains lessons of importance to both military and civilian medical establishments. The question of the necessity for a special commission with such powers is debatable, and cannot be discussed without full consideration of the structure of the military services and the limitations placed upon functions of the regular medical departments. The problems of administration of a semi-autonomous commission in relation to the three great medical services, the successes and failures of the Commission, the operational and scientific activities of the Commission will be dealt with in a separate historical publication. It is sufficient to note here that the Commission was active in the United States and all theaters of operation overseas from January 1943 until the end of June 1946, when it was dissolved. It served as a main center of investigation and control of typhus fevers in the world-wide attack on those diseases required by the global military operations of American forces.

Practical results of importance and lasting benefit came from the collaboration of all the agencies mentioned above. In terms of products the two most notable achievements were the improvement of typhus vaccine and the development of lousicidal preparations, chiefly a powder, containing DDT (dichlorodiphenyltricholorethane), discovered by Zeidler[41] in 1874. In terms of practice the method of using the vaccine for immunization and the methods of applying the louse powder to persons fully clothed were long steps ahead. In fact the utilization of DDT louse powder to control typhus was a revolutionary advance.

In 1941 it was foreseen that American troops might be sent to regions where typhus was prevalent. Although forecasts were made in 1942, the extent of the risk from exposure to infection was not known until afterward. The year 1942 was an epidemic typhus year among civilians in the Mediterranean region, from Morocco to Iran [4, 20]. In 1943-44 at a critical time in the Italian campaign there was a sharp and potentially dangerous outbreak of typhus in devastated Naples. Upwards of 20,000 cases of typhus were uncovered in the Rhineland, Inner Reich and Austria in the spring of 1945, while American troops were advancing. In the winter of 1945-46 the most severe epidemic of typhus in recent years occurred in Japan and Korea during the first six months of the occupation of those countries. The approximate numbers of reported cases among the civilians in these countries during the years 1942 to 1946 are summarized in Table II. From what is known about the deficiencies of the reporting systems in these countries, particularly during the war, it is reasonable to estimate that there were actually four to five times as many cases as the numbers reported.

TABLE II

Approximate Numbers of Reported Cases of Epidemic Typhus Fever Among Civilians in Various Countries During World War II.

Countries	1942	1943	1944	1945	1946 (4 mths.)
French North Africa (Morocco, Algiers)	77,335	27,340	6,226		
Egypt	23,941	40,084	18,533		
Iran	1,102	12,885	6,436		
Italy (chiefly Naples)	0	481	1,409		
Germany, Austria (occupied)	?	?	?	20,000	
Japan	100	1,414	3,964	2,460	27,150
Korea	3,150	8,850	5,400	13,100	4,100

There were only 64 reported cases of epidemic louse-borne typhus and no deaths from the disease among all American military personnel in all these typhus-infected areas during the years 1942 to 1946. The number of cases is probably less than 64, as it is believed that some cases in refugees and German prisoners treated in American military hospitals are included in the reports. Taking the number as 64, Sadusk[30] has calculated that the rate of epidemic typhus in the total American Army was 0.003 per 1000 per annum, with rates of 0.01 in the European Theater and 0.13 in the Mediterranean Theater of Operations. Among these cases there were instances of infection acquired not directly from lice but by the inhalation of infected louse feces or by entry of such material into the conjunctival sac.

The low incidence of typhus in American soldiers is attributed primarily to their freedom from lice and to the protective action of louse powders. The mildness of the disease, without fatality, is attributed to immunization by the vaccine, which ameliorates the disease although it does not prevent infection[30].

Starting early in 1942 all United States military personnel stationed in or travelling through where typhus was known to exist were vaccinated against typhus[30]. As the destination of troops was not predictable, the vaccine was administered almost throughout the Army. The vaccine used was of the "Cox type," consisting of a suspension of typhus rickettsia of the Breinl strain cultivated in embryonated hen's eggs, extracted with ether according to Craigie's method, and fortified by the addition of specific rickettsial soluble substance[14, 15, 27, 35]. To get the advantage of revival and heightening of immunity by "booster doses" individuals were reinjected with the vaccine at intervals of 6 months or oftener, depending upon the risk of exposure. Vaccination against typhus is an essential means for saving lives. There is some evidence also that while vaccination does not prevent infection, it does decrease transmissibility of infection by lice which have fed upon a vaccinated typhus patient. The use of the vaccine to control epidemics among civilians has been questioned. It is, however, of undoubted value in preventing loss of key personnel, as well as in saving lives generally, and it may lower the epidemic potential.

During 1943 the remarkable insecticide now known as DDT displaced the previous ineffective and impractical methods for controlling lice[1, 9, 16, 31, 33]. In contrast with the former cumbersome bathing establishments, steam and hot-air disinfestors, fumigants and ephemeral insecticides, which left the treated persons and their clothing vulnerable to reinfestation at the next encounter with lice, DDT killed body lice rapidly enough and had a residual effect, lasting as long as a month after application to clothing. In the form of a powder containing 10 per cent of DDT in pyrophyllite, it was easy to apply from 2-ounce shaker tins or by hand dusters or power-driven dusters, modified from agricultural types of sprayers. The methods of application of DDT powder to persons fully clothed[32], as worked out chiefly by the Rockefeller Foundation Typhus Team in Algeria in collaboration with the Preventive Medicine Section of the Office of the Chief Surgeon of the North African Theater of Operation, were simple, effective, and agreeable to the recipient. They permitted the delousing of thousands by a few operators in a short time. Enormous quantities of DDT were produced in the United States within a year and tons of the powder were sprayed on refugees, displaced persons, and citizens in North Africa, Italy, Yugoslavia, Germany, Austria, Japan and Korea during the years from 1943 to 1946. Large and small outbreaks of typhus were promptly controlled, and an incalculable number of infections prevented.

The chief examples of the effective control of outbreaks of typhus among civilians in occupied countries during World War II were the epidemic at Naples[12, 38] during the winter of 1943-44, the outbreaks in Germany and Austria in the spring of 1945, and the wide-spread epidemic in Japan and Korea from December 1945 to May 1946. In each region a dangerous epidemic was quickly brought under control, removing the hindrance to military operations and saving the people from the ravages of a pestilence formerly regarded as an inevitable accompaniment of war and famine.

A complete program for typhus control derives from principles insisted upon by Chapin and others; namely, accurate knowledge of the situation, purposeful education and training, and full utilization of the best available means and measures

continued on next page

for control. With respect to typhus, the elements of the program may be summarized as follows:

I. Case finding, reporting and dissemination of information on the situation.
II. Isolation of cases by removal of patients to hospitals or by putting a barrier of DDT around the patient by dusting his body, clothing, and environment.
III. Contact delousing with DDT.
IV. Mass delousing by dusting with DDT entire populations of cities or regions.
V. Immunization, especially the vaccination of key personnel.
VI. Establishment of a "cordon sanitaire" along border stations for inspection and delousing of refugees, repatriates and groups and individuals in transit.
VII. Education of the people by posters, newspaper articles, talks, broadcasts and motion pictures; enlistment of the cooperation of the people.
VIII. Training of personnel in typhus control methods.
IX. Arrangements for adequate funds, supplies and transportation.

In this program of control of epidemic typhus the attack upon the louse vector is the primary aim. Hence, the use of DDT is the main factor. Indeed, some have expressed the opinion that the use of DDT alone will be sufficient to prevent and control typhus. While there is much truth in this statement, it is not complete. Each of the other measures is important during epidemics. In addition, both during epidemics and in seasons between epidemics, typhus fever can be held in check by operation of improvements in social and economic conditions as measured by adequate supplies of soap and food.

Endemic Murine Flea-Borne Typhus

Endemic or murine typhus was ten times as prevalent as epidemic typhus among United States military personnel during World War II. During the years 1942 to 1945, 603 cases were reported in soldiers[30]. Of these, 414 cases occurred in troops stationed in the endemic areas in the southeastern and southwestern regions of the United States, where most of the infection was acquired in towns adjacent to Army posts. Of the cases in troops overseas, 13 occurred in South and Central America and 176 in the Pacific Ocean area. As the disease was mild, with a low case fatality rate of 2 to 5 per cent, it had none of the serious implications of epidemic typhus. A vaccine against murine typhus was not used in the American Army, although the British typhus vaccine contained both murine and epidemic types of rickettsiae. The control measures were directed against rats and their ectoparasites, chiefly the main vector, the rat flea, *Xenopsylla cheopis*.

The disease was of constant interest to military preventive medicine. As a result of surveys made during the war, its world-wide distribution was more clearly recognized than before. The proof of its existence in the Philippines[39], for example, was a product of war-time research, and at present unofficial reports from Army laboratories in Japan indicate that murine typhus has been the most prevalent form of the disease in certain areas this year.

Murine typhus is of such great importance for civilian public health in the Southeastern and Southwestern states of this country that its control has become a major undertaking of the United States Public Health Service in collaboration with State departments of health. Since 1930, the number of reported cases in the United States has increased annually from 510 to a peak of 5,346 in 1944, since when the incidence has declined. While the number of cases has been increasing, the disease has invaded new sections of the Southeastern States and other regions of the country. Approximately 97 per cent of all cases have been reported from Alabama, Georgia, Florida, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Texas. The remaining 3 per cent has been widely distributed. Concentrations of cases have occurred in Los Angeles County, California; Pulaski County, Arkansas; Norfolk area, Virginia; and in the New York City area. Statistics of the incidence of murine typhus fever in the United States from 1930 to 1946 are presented in Table III.

TABLE III

Murine Typhus Fever in the United States 1928—1946; Statistics from the U. S. Public Health Service.

Year	*Cases Reported*	*Year*	*Cases Reported*
1930	510	1939	2998
1931	332	1940	1882
1932	955	1941	2782
1933	2069	1942	3736
1934	1372	1943	4530
1935	1287	1944	5346
1936	1732	1945	5193
1937	2392	1946	3366
1938	2294		

To control the disease, extensive efforts have been made to get rid of rats, which are the reservoir of the infection. Rat-proofing of buildings and rat-poisonings have been applied with varying degrees of success. Among the rat-poisons, sodium fluoroacetate, so-called 1080, a product of war research, appears to be highly effective. Lately the attack has been directed also against the rat flea by dusting with DDT powder all reachable rat-runs,

burrows, and haborages, and areas of passage in which rats might collect DDT on their coats and carry it to their nests. The early evidence that DDT might be useful for this purpose came from incomplete field trials in Algiers and Dakar during the war, in situations where protection from plague as well as from murine typhus was desired. It is still too soon to evaluate the results, but the indications are that DDT dusting combined with rodent control is reducing the incidence of murine typhus in this country[23].

Scrub Typhus — Tsutsugamushi Disease — Mite-Born Typhus

When the United States entered the war in the Pacific area in 1941 scrub typhus was vaguely identified with tsutsugamushi disease, or Japanese river fever, and was regarded as an interesting exotic disease of sporadic occurrence. Its importance from the military point of view was not appreciated until infections occurred in troops during the operations in New Guinea during the fall of 1942. In the following years, until the surrender of Japan in August 1945, it increased in importance and terror from New Guinea and adjacent islands to the Philippines and in Assam and Burma, particularly along the Stilwell or Ledo Road. During the years 1942 to 1945, 6,685 cases of scrub typhus were reported among American troops[30]: Of these, 5,718 occurred in the Southwest Pacific Area and 967 in the China-Burma-India Theater. The case fatality rate ranged from about 1 per cent to as high as 28 per cent.

Extensive field and laboratory investigations of scrub typhus were carried out. Many urgent problems were solved and permanent additions were made to scientific knowledge[5, 24]. The outbreaks came upon troops in the field and were provoked, as it were, by the placement of troops in certain types of terrain, such as areas of Kunai grass in New Guinea or the scrub or low-bush areas of Owi and Biak. Some combat units were rendered ineffective. General anxiety increased. In its effects upon troops and military operations scrub typhus was far more important than epidemic louse-borne typhus.

This disease is caused by a rickettsia called *R. orientalis* or *R. tsutsugamushi*. Its reservoir in the Southwest Pacific and in Assam and Burma appears to be chiefly field rats. The infection is transmitted by the larvae of trombiculid mites, especially *Trombicula deliensis*, and *Trombicula fletcheri*, a variant of *Trombicula akamushi*. In the mites the infection is transmitted by transovarial passage, so that an area of ground colonized by infected mites may be widely and patchily "contaminated." Man is infected when the laval mite establishes its feeding tube in the skin of the individual to which it has become attached.

Neither the disease nor any known mite vectors of it exist in the United States. It is to be hoped that it will remain a disease of exotic interest to the inhabitants of this land. As long, however, as United States troops have to operate in certain regions of the Pacific areas, the disease will be of personal as well as military concern to our people.

No vaccine was available for immunization against scrub typhus. A vaccine made in England[19] from scrub typhus rickettsia obtained from the lungs of experimentally infected cotton rats came too late for extended field trials. The same may be said of scrub typhus vaccine made in this country at the Army Medical School and at other laboratories, including those of a manufacturing firm. There are indications, however, that these vaccines have promise of providing some degree of protection. If immunization ameliorated the disease and decreased the mortality, it would be a great gain.

Protection from attack by chiggers or red-bugs, the larvae of trombiculid mites, has been of interest to the people of this country for a long time. Common annoyance from chiggers brings the problem of control closer home. The results of intensified investigations made during the war to control scrub typhus by attack against mites will spread to civilian comfort.

Control measures against scrub typhus were worked out with difficulty in the field in New Guinea during 1943 to 1945[6, 7, 8], and in this country through collaboration with the Bureau of Entomology and Plant Quarantine of the Department of Agriculture. Two basic principles laid down some 30 years ago by the United States Department of Agriculture were followed. These were (1) individual protection through wearing chemically treated clothing and (2) elimination of chigger breeding by chemical treatment or by changing the ecology of an area so that mites could no longer survive in the soil.

During the war the Australians established the fact that dibutyl phthalate was an effective laundry-resistant miticide when smeared by hand at the rate of one ounce over a uniform. Members of the United States of America Typhus Commission developed a simple and rapid means for impregnating uniforms by dipping them in an emulsion of 5 per cent dimethyl phthalate in 2 per cent solution of laundry soap. This method of treatment of uniforms was used successfully by American troops from the middle of 1944 until the end of the war[6, 7, 37]. It had the disadvantage of being temporary, as the dimethyl phthalate was leached out by rain, immersion in water and by laundering. Before the end of the war, it was found that benzyl benzoate was a more effective miticide and that uniforms impregnated with this compound re-

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mained miticidal even after two launderings with soap and water. Since then reports from the Bureau of Entomology and Plant Quarantine[8] indicate that benzil and dichlorodiphenyl are superior and more resistant to laundering than benzyl benzoate.

Application of sulfur dust, DDT and fuel oil were tried in area-control, to produce conditions unfavorable to the breeding of mites. Their effects were not satisfactory. Unpublished reports from the Bureau of Entomology and Plant Quarantine, presented by Bushland[8] at the AAAS Symposium in Boston in December 1946, indicate that hydroxypentamethylflavan and benzene hexachloride applied either as dusts or sprays, at dosages as low as 4 to 6 pounds per acre, may eliminate mites from an area for at least a month after treatment.

About twelve years ago Doctor Hans Zinsser[42] made this prophesy: "Typhus is not dead. It will live for centuries, and it will continue to break into the open whenever human stupidity and brutality give it a chance, as most likely they occasionally will. But its freedom of action is being restricted, and more and more it will be confined, like other savage creatures, in the zoological gardens of controlled diseases." During the World War of 1939 to 1945, both parts of this prophecy were fulfilled. Typhus reappeared in epidemics in the conditions produced by human stupidity and brutality. In the same period, however, human intelligence and cooperation in self-preservation produced and used the powerful new weapons which have subdued the disease. The accomplishments in the control of epidemic typhus during the war make a notable chapter in military preventive medicine. These gains are now available to civilian public health. They indicate that given the will and the means to apply existing knowledge, no country needs to suffer again from a devastating epidemic of typhus, and that this disease and its relatives may be reduced to minor causes of sickness.

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CHANGES IN MEDICAL PRACTICE*

President's Address

HERMAN C. PITTS, M.D.

The Author. *Herman C. Pitts, M.D., of Providence. President, Rhode Island Medical Society, 1946-1947. Former President of the American Cancer Society.*

IN this very short address this afternoon, I shall not attempt to suggest plans for the future betterment of the Rhode Island Medical Society in particular, or the medical profession in general. The future most certainly lies in the hands of the younger generation. Youth looks forward, while old age looks backward to methods of action and modes of thought that seem to him still worthy of present day consideration.

And so I claim the privilege of discussing why the medical profession of 47 years ago functioned as well as it did, and why we should still bear in mind some of the lessons that older generation can teach us.

Going far, far back beyond those very short 47 years, we find medicine gradually emerging from the age of augury, of priestcraft, of sorcerers and charlatans. A very few, very brilliant, really scientific minds had visions of what was to come. But the lack of instruments of precision kept their visions from becoming reality.

We can have little conception in this day of many microscopes what Jannsen's discovery in the early 1600's really meant. A whole new world was opened wide almost over night.

That didn't mean that the average physician treated his patients with any greater intelligence. The accumulating knowledge was only for the few and did not in any way affect the average man.

In the light of present day knowledge it is hard to understand what those old fellows contributed to the health of their communities. Certainly there was nothing scientific in their approach to illness. And yet if we could project ourselves backward say to the days of the 18th and 19th centuries, I am quite sure we would find that the physician then had a standing in the community, a position of authority that should be the envy of any of us today. They were given credit, of course, for a great deal they didn't know, just as we are now given credit for knowledge that would be superhuman. Yes, it seems incredible that during all those years of ignorance when medicine was groping toward the light, her disciples—the so-called doctors, could have been held in such high esteem. The very fact that they were makes it certain that by and large they did some good. Otherwise, they would have been thrown out lock, stock and barrel as they were in the capitol of Guatemala in 1541 when the practice of medicine was forbidden by law because of the deaths that dogged the footsteps of the one physician there.

If the early physician knew very little beyond the use of a few simples of minor value and the use of a lot of horrible concoctions of no value at all, wherein lay the dependence of the human race on their administrations?

Arthur Young in his notes on "Travels in France in 1789" suggests, I think, a reason when he says, "there is a great deal of difference between a good doctor and a poor one, but very little difference between a good doctor and no doctor at all"— implying that a good doctor even of those days helped his patient not by excessive and often harmful drugging, not by bleeding and emetics, but by wise dependence on nature—by giving a boost to the morale of the sick person and by careful regulation of diet and activities. In other words, in the absence of scientific medicine, he had developed the art of medicine. And the art lay then and lies today in the ability of the wise physician to so win the confidence of his patient that fears are allayed, the mind put at rest and the stage set for the recuperative powers of the body to do their part in restoring health.

No, I am not a Christian Scientist, but I do believe as Osler taught that when the body is sick, the mind is sick and unless the physician is able through art to restore the mind to proper functioning, the body lags behind in its recovery.

During my medical course we had a series of lectures by one of the deans of the profession in New Haven. I think of him as a handsome, gray haired gentleman in his late sixties. He talked on Medical Ethics and Medical Etiquette. I remember practically nothing of what he said. That could hardly be expected of one in the process of being stuffed with scientific knowledge, but I am quite certain we could have learned many useful lessons

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* Delivered before the 136th Annual Meeting of the Rhode Island Medical Society, at Providence, May 15, 1947.

from that kindly gentleman's vast store of medical experience. How little the young man knows of the proper approach to private patients and how much he could learn from just such lectures if he had wisdom enough to listen! A case in point—Two different young men had occasion to do something for a patient of mine in Jane Brown Hospital on successive days. The first is a man of real ability—he knows medicine and the patient had to admit he was skillful—but she didn't like him. The second is good, but not quite up to the level of the first, and my patient liked him much better. I was interested to know her judgment of the difference between the two. "Well," she said, "the first man went at me without saying a word, without any greeting, without explaining what he had to do. He was coldly businesslike and left me feeling mine was just one of the many tiresome jobs he had to finish in a given time. The other came in with a smiling 'Good morning', explained somewhat of the reason for his visit and went away leaving me feeling like a real human personality." The first young man unless he changes, will always practice scientific medicine. He may be successful, but he will miss the great satisfaction that comes from having a following of very loyal, very devoted patients. On the other hand, the second young man, if he continues to mix a good measure of the Art of Medicine with what is scientifically sound, will find the satisfaction in his practice that will be denied the first.

As I saw the older physicians in the early days of my practice, they used the Art of Medicine to a very great extent. Their scientific knowledge as measured by present day standards was not to be compared with that of one of our recent graduates in medicine. And yet, by and large they did quite as much for suffering humanity through their acquired wisdom as the most brilliant of our graduates will be doing after 20 years in practice. They were dictatorial. Their attitude of authority, which no one of us of the present dares to assume, gave them such a tremendous standing in the minds of all people that I often think their patients got well because they were told they would!

I can very well remember several years ago meeting one of Providence's old dowagers on the street. She stopped me to ask if I could recommend a good medical man. I thought I knew several and mentioned their names. "Oh," she said, "I have been to every one of them and what do they do but tell me I must have my eyes examined, or an x-ray of my stomach, or my blood chemistry taken or some other perfectly foolish thing done when all I need is some good advice and encouragement and a little medicine. Since Dr. Gardner died, I haven't found anyone who has a particle of common sense. In the old days when I didn't feel well, I either went to his office or he came to the house. I told my story. He asked a few questions. Then he would write a prescription or give me a few pills and say, 'Take this medicine for a few days and you will be well,' and sure enough—I was!".

I do not mean to advocate slip-shod, careless methods of examination, but I am certain that Dr. Gardner's knowledge of human nature in general and the characteristics of the patient under consideration in particular, made it perfectly safe for him to treat her more by Art than by Science, to the saving of much time on his part and much expense on hers.

Again those older men relied much more on their senses than do we of the present day. This is a mechanical age and being such, I presume it is quite natural that the younger generation turns more and more to mechanical aids to diagnosis in illness. No one can gainsay their value—but for Heaven's sake let us train the senses God has given us and use them first and then if more help is needed, call in any and all of the gadgets that will be of any use. The cost of medical care has already risen to a point where the average man cannot afford the luxury of illness for himself and family. The too free use of mechanical aids steadily increases the cost and by so doing in turn increases the demand for State medicine.

I believe medicine will be kept on a surer footing if all physicians, and particularly our younger men who really hold the future of medicine in their hands, remember that there is room for Art as well as Science in the practice of medicine. Science deals with the pathologic aspects of illnes; Art with the rather intangible thing called "morale" and the subtle effect of the mind on the functions of the body.

After all, the future of medicine depends very largely upon our relations with the public and the character of those relations rests in the hands of each and every one in the medical profession. If he —every individual physician—makes himself as proficient in the Art of Medicine as he must be in the Science of Medicine, there is no question but that the future of our great profession is assured.

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THE MEDICAL EXAMINERS' PROBLEM IN RHODE ISLAND*

ALBERT J. GAUDET, M.D.

The Author. *Albert J. Gaudet, M.D., of Pawtucket, R. I. Medical Examiner, District Eight, Rhode Island.*

I HAVE BEEN Medical Examiner of District 8 in Rhode Island — which covers Pawtucket and Central Falls—for about a year and a half. This constitutes my entire experience in Medicolegal work, so it is quite obvious that I cannot be qualified as an expert in this highly specialized field. Accordingly, I feel quite brazen standing here tonight speaking to you learned gentlemen about Medical Examiners. However, I have done considerable reading on the subject and was exposed to an excellent seminar in legal medicine last October at the Harvard School of Legal Medicine where Dr. Alan Moritz and his associates conducted a very interesting and instructive course on the subject. My year and a half as Medical Examiner has been a very busy one—and I have had quite a variety of cases—all the way from simple unattended deaths to homicide. Because of my reading, my attendance at Harvard and my experience, I have developed a few ideas concerning Medical Examiners, their duties, and in particular, the failings of the law in Rhode Island. These ideas I would like to present to you tonight for your consideration.

I doubt if there is any public office in these United States that has more variable characteristics than that which I hold at present. The method of selection varies from state to state—election by popular vote, patronage appointment and selection based on ability and qualifications—one of these is the usual method. In Rhode Island, Medical Examiners are appointed by the Attorney General and hold office at his pleasure. The duties of the Medical Examiner also vary widely—all the way from the restrictive law of Tennessee which states that only when "there is good reason to believe that such person came to his death by unlawful violence at the hands of some other person"; or that of Michigan where an investigation is justified when "there is good reason to believe that murder or manslaughter has been committed"; to the quite adequate laws of New Jersey which I will quote a little later on. The law in Rhode Island is very vague and certainly is not adequate for the proper direction and protection of the Medical Examiner. This will also be enlarged upon a little later. Even the titles of the investigator vary from one state to another—for example, Medical Examiner, Medical Referee, Coroner, etc. It can be seen that there is no uniformity as regards the selection and duties of Medical Examiners. I realize that uniformity throughout the forty-eight states is not necessary for the proper and efficient discharge of this important office. However, adequate legal backing should support the Medical Examiner so that he can fully discharge his duties for the protection of the public welfare. Rhode Island is lacking in this respect and I believe this Society should initiate action for the correction of this evil.

The power and the duties of Medical Examiners in the State are prescribed by the provisions of Chapter 409 of the General Laws of 1923 and the Amendments thereto, plus a reference to the subject in section 6 of Chapter 166. Much of Chapter 409 deals with appointments—which we have already mentioned—records to be kept and submitted by the Medical Examiners—which could be improved upon—and the fees which the Medical Examiner shall receive. In Rhode Island, Medical Examiners are paid five dollars for viewing a body and twenty-five dollars for an autopsy. This in itself is an evil, for since the Medical Examiner's income is determined by the number of cases he handles, it is only natural that the public welfare is not his only consideration in determining which cases he shall investigate and "take over".

Sections 8, 9, 10, 17 and 23 to 32 inclusive deal with the powers and duties of the Medical Examiner. Without going into too much detail, I would like to quote the pertinent parts of these sections so that you can understand my statement that the laws of Rhode Island are vague and inadequate. Section 8 provides as follows: "Medical Examiners shall make examinations as hereinafter provided upon bodies of such persons only as are supposed to have come to their death by violence; Provided, that in case any prisoner in the State prison or in any county jail dies while so imprisoned, it shall be the duty of the medical examiner of the district

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* Presented at Quarterly meeting of the Rhode Island Medico-Legal Society, at Providence, April 24, 1947.

in which such prison or county jail is situated, upon being notified of the death of such prisoner, to make at once examination upon the body of such deceased prisoner."

This Chapter appears to be self-explanatory, except that the word "supposed" is very indefinite. The exact interpretation of this word has never been passed upon by our State Supreme Court. A definition is available from an Ohio Case—the case of the State of Ohio vs. Bellows. This definition states—"death is supposed to have been caused by violence when a dead body is found in the County, whenever, from such observation as the Coroner may be able to make, and from the information that may come to him, there is substantial reason for belief or surmising that death was caused by unlawful means." Now—as you can readily see—this is all very vague and non-specific. Even the broadest interpretation leaves much to be desired —for example—cases admitted to a hospital and who die within 24 hours of admission, cases of fulminating infection or insidious poisons which endanger the public welfare—these and other cases are not provided for under our present statutes.

Section 9 states: "When a medical examiner has notice that there has been found or is lying, within his district, the body of a person who is supposed to have come to his death by violence, he shall forthwith repair to the place where such body lies and take charge of the same; and if, on view thereof and personal inquiry into the cause and manner of the death, he deems a further examination necessary, he shall, upon being thereto authorized in writing by the attorney-general, or by the mayor of the city or president of the town where such body lies, make an autopsy in the presence of two or more persons as witnesses, and shall then and there carefully reduce, or cause to be reduced, to writing, every fact and circumstance tending to show the condition of the body and the cause and manner of death, together with the names and addresses of said witnesses, which record he shall subscribe. Before making such autopsy, he shall call attention of the witnesses to the position and appearance of the body. If such body be found at the residence of the deceased, a medical examiner shall not remove such body therefrom unless necessary for further examination or autopsy. Such examiner shall, after any required examination or authorized autopsy, promptly deliver or return such body to the relatives or representatives of the deceased, or if there are no relatives or representatives known to the examiner, he shall cause the body to be decently buried, except that such examiner may retain as long as may be necessary, any portion of such body necessary for the detection of any crime."

As you can see, this section gives the procedure to follow in those cases requiring autopsy. I have no quarrel with the present Attorney General's Department in this regard, for I have had the fullest cooperation and have been allowed considerable latitude. However, the fact still stands that non-medical personnel, holding political offices, must give permission to the Medical Examiner before an autopsy can be performed. That this is an undesirable feature of our Law as it stands can hardly be refuted. I believe that if a Medical Examiner is qualified to carry out his duties properly, he should also be qualified to determine when an autopsy should be performed. No other permission should be necessary—and certainly it is not desirable.

Section 23 states: "If a medical examiner reports that a death was not caused by the act or neglect of some person other than the deceased, the attorney-general may, notwithstanding such report, direct an inquest to be held in accordance with the provisions of this chapter; at which inquest he, or some other person designated by him, shall examine all the witnesses."

This is a good feature in the law as it stands—for certainly the Legal Authorities should have the right to order an autopsy and an inquest even if the Medical Examiner is contrary minded.

Section 24 states: "The medical examiner may, if he deem it necessary, employ a chemist to aid in the examination of the body, or of substances supposed to have caused or contributed to the death; and such chemist shall be entitled to such compensation for his services as the medical examiner certifies to be just and reasonable, the same being audited and allowed in the manner hereinafter provided."

This section should be revised to include other experts such as photographers, ballistic experts, etc. Modern day medicolegal criminology requires the close cooperation of many experts—not just that of a chemist or toxicologist.

Section 25 and the amendment thereto, Section 2 Chapter 659, deal with the disposal of unidentified or unclaimed bodies. This section could stand revision for it leaves the door wide open for discreditable alliances between overseers of the poor and undertakers.

Sections 26 and 27 deal with recovery fees to be paid when a dead person is found in a body of water and with the disposition of valuables and property of the deceased. These Sections seem to be fairly adequate and, I believe, require little change.

There is nothing else in the General Laws to guide the Medical Examiner. Furthermore, there is nothing in the Law to guide the Attorney General in appointing Medical Examiners.

From what I have said up to this point, I think it is quite evident that the Law governing the duties of a Medical Examiner in Rhode Island are totally inadequate. Undoubtedly it is the intent of the

law not only that the true cause of death be established with the greatest possible precision but also that all evidence pertaining to the circumstances thereof be acquired. To attain the desired end of fulfilling the office of Medical Examiner for the best interests of the public welfare, "intent" is not sufficient. There must be adequate and clear laws to give the Medical Examiner every assistance in the proper and useful discharge of his office. In this respect New Jersey has a very good law—lacking only in two minor points. It states; "When, in the county, any person shall die as a result of violence or by casualty or suicide, or suddenly when in apparent health, or when unattended by a physician, or within twenty-four hours after admission to a hospital or institution, or in prison, or in a suspicious or unusual manner, the police department of the municipality in which he died, the superintendent or medical director of the institution in which he died, or the physician called in attendance shall immediately notify the office of the chief medical examiner of the known facts concerning the time, place, manner and circumstances of the death. Immediately upon receipt of such notification the chief medical examiner, or an assistant medical examiner, shall fully investigate the essential facts. If necessary he shall go to the dead body and take charge thereof." This law would be improved by the incorporation of a provision requiring medicolegal investigation of deaths of persons whose bodies are to be cremated, plus a more specific statement of "when unattended by a physician". I believe a specific time should be set, say "when unattended by a physician within one week of death".

As regards qualifications of officials responsible for the investigation of deaths in the interests of public welfare, much can be said. It is obvious that the law should require that the office of medical examiner be occupied by a physician. It is equally obvious that he should either be a qualified pathologist or be required to employ the services of a qualified pathologist for the performance of autopsies.

Whenever doctors are responsible for the establishment and maintenance of organized medical facilities for the care of the sick, provision is almost invariably made whereby a physician who is skilled in the science of pathology is made responsible for the performance of autopsies. Without in any way detracting from the importance of autopsies performed for scientific or educational reasons it should be pointed out that only when an autopsy is medicolegal is it likely to have an immediate and direct effect on the life, liberty or property of some person. On the outcome of a medicolegal autopsy may depend the life or freedom of a suspected person. On the outcome of a medicolegal autopsy may depend the indemnification of a widow or the liability of an employer or an insurer. With such issues at stake it is strange indeed that only when an autopsy is performed in the interest of justice is it entrusted in many instances to some one lacking proper qualifications for its conduct.

To appraise the relative merits of the political and non-political methods for the selection of official medical investigators it is necessary to consider for a moment the nature of the public service expected of them. They function as scientific, fact-finding agencies. Incompetence or partisanship on the part of such an official may be responsible for the non-recognition of crime, for the non-prosecution of criminals, for the unjust prosecution of innocent persons and for miscarriage of justice in courts of civil law. Their functions are in no way policy forming.

There has been a growing recognition in this country of the fact that public servants whose duties are technical and not policy forming should be selected by different means than are employed for the selection of public servants whose duties include policy determination.

It is a fact that medical science participates less effectively in the administration of justice in the United States than it does in any comparable civilized country in the world. An important, if not the principal cause of this deplorable condition, is the fact that official medical investigators are selected in most states by political methods rather than by the merit system. The practice of selecting official medical investigators by direct vote of the electorate or by some form of political patronage has led to the systematic scrapping of invaluable experience, has placed persons in office who are not only inexperienced but not infrequently incompetent as well, has predisposed to partiality in the conduct of public business and has discouraged from entering public service the very kind of physician that should be engaged in this important type of work.

As regards specific suggestions as to changes in the present law—I think I can best cover this part of my talk by quoting from the report of the Committee of the A. M. A. to Study the Relationship of Medicine and Law—the report from which much of what I have already said has been taken. In reporting on model legislation the Committee has this to say, and I quote:

1—That the official investigator shall be responsible for determining the cause of death and such medical or other information from an examination of the body that may indicate the manner of death.

2—That it shall be the duty of a magistrate of a county or municipal court to hold an inquest if in the opinion of the official investigator or the county attorney such a procedure is indicated.

3—That it be stipulated that the official investi-

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gator shall be a qualified physician and that he shall be selected and retained in office under some form of the merit system rather than by political preference.

4—That the official investigator shall be notified when in his county (or jurisdiction) any person shall die of violence or suddenly while in apparent health or from obscure causes or when unattended by a physician or in any unusual or suspicious manner, or when in his county or jurisdiction the body of any dead person is to be cremated. Immediately on receipt of such notification the official investigator shall go to the place where the body lies and take charge of it. He shall then and there make a written description of the body and the premises, which report, together with an opinion regarding the cause and manner of death, he shall have copied and within seven days give one copy to the county attorney.

5—That, if in the opinion of the official investigator or the county or state's attorney it is in the interests of public welfare to perform an autopsy on the body of a person whose death occurs under the purview of the law, such an examination shall be performed or caused to be performed by the official investigator.

6—That an official autopsy may be performed by the official investigator if he is a qualified pathologist and, if not, the official investigator shall engage the services of a qualified pathologist for the performance of such an autopsy.

7—That the official investigator may, within the limits of the funds supplied his office by the county budget commissioner, engage the services of a toxicologist to assist in the investigation of the cause of circumstances of any death coming within his purview.

8—That there be created (for the benefit of communities not already supplied with such facilities) a state consulting laboratory having professional and technical facilities for assisting official investigators in the conduct of pathologic and toxicologic investigations on the bodies of persons whose deaths come under the purview of the law.

In concluding, I think it is safe to say that the ineffectual manner in which medical knowledge and skill are utilized in the Administration of justice in the State of Rhode Island undoubtedly predisposes to:

1—The nonrecognition of murder.

2—The unjust accusation of innocent persons.

3—The improper evaluation of medical evidence bearing on the circumstances in which fatal injuries were incurred.

4—Failure to acquire medical evidence which would be useful in the apprehension of criminals.

5—Failure to acquire medical evidence essential to the administration of civil justice.

6—Ignorance of certain otherwise preventable hazards to public health, and

7—The impairment of the value of vital statistics.

Finally, I believe that this Society and the State and County Medical Societies should initiate—and follow through to enactment—legislation that will correct the evils that now exist in the medicolegal laws of our fair State.

THE CONTROL OF TYPHUS FEVER

concluded from page 430

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THE MEDICAL EXAMINER SYSTEM

ELSEWHERE in this issue is an article entitled, "The Medical Examiners Problem in Rhode Island," written by a medical examiner. At a recent meeting of the House of Delegates of the Rhode Island Medical Society, without cognizance of this article, a committee was appointed and the Rhode Island Bar Association was requested to appoint a cooperating committee for the purpose of studying and making recommendations concerning the Medical Examiner System in Rhode Island.

It is fitting that the physicians of Rhode Island should be interested in the Medical Examiner System. If medicine is able to contribute to legal procedure and to the promotion of law and order then all doctors should be concerned with the machinery designed to accomplish this. Whether or not the system offers the greatest possible help and protection to the public is of first importance. Whether or not it is carried out in a way that affords satisfaction and credit to the physicians who act as medical examiners and to the medical profession of our state is also a legitimate concern.

For many years we have heard criticism of and expressions of dissatisfaction with the Medical Examiner System. These have come from medical examiners, from other physicians, from judges and lawyers, and from nonprofessional people. There seems to be an impression that the system is not so good as it might be. Much of this, however, is based upon assumption and hearsay. We are unaware of any systematic study designed to collect factual data concerning all details of the system. The report of Mr. Bruce Smith, made about two years ago for the Rhode Island Public Expenditure Council, centered largely upon the qualifications of medical examiners to make postmortem examinations. While this is important it is, in our opinion, a very small part of the problem and one that can be readily improved.

Study should include the method of selecting and appointing medical examiners. It seems obvious that merit rather than political expediency should be the basis of selection and that tenure of office should be for long terms and should not be endangered by political changes. Perhaps appointment by a nonpartisan commission from doctors nominated by the local medical societies, as is now the method in Virginia, might be desirable.

The method of compensation might be worthy of study. Possibly the present fee system is not best from the standpoint of either the public or the medical examiner.

The authority of medical examiners needs to be defined. It is undesirable that in medical fields they should be subject to being overruled by political or legal officials.

The duties of medical examiners should be defined. As we see it, their duty is to investigate all sudden, unexplained or suspicious deaths in order to determine whether or not there is reason to

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suspect legal complications. In many cases this investigation will not reveal any indication for a postmortem examination. We suggest that when the medical examiner does decide that a postmortem examination is needed, he is entitled to and should be required to have the assistance of experts in pathology and toxicology. This would place upon the state responsibility for furnishing such experts as well as the necessary laboratory space and equipment.

Careful study of all aspects of Rhode Island's Medical Examiner System by the medical and legal groups should bring out the strong and the weak points of the system and suggest ways of strengthening the weaknesses.

PHYSICIANS HONORED

The more esoteric members of our profession, the internists, have just been foregathering at the annual session of the American College of Physicians at Chicago. Progress in Internal Medicine has been truly phenomenal in the last ten or fifteen years, and the impressive program dealt with many subjects unknown to the well-informed doctor of two decades ago.

Rhode Island has an enthusiastic group of members who were well represented there. Dr. Alex M. Burgess, Governor of the College from this state for several years, ended his term of office and has a worthy successor in Dr. Herman A. Lawson. Dr. Lawson's qualities as an administrator are as well recognized as his clinical abilities. He showed that when as Colonel he headed the Rhode Island Hospital Unit in India. Added confirmation is now given by his appointment to the Board of Hospital Commissioners of Providence.

But the College has not lost the services of Dr. Burgess's guiding hand. He has been advanced to the position of Regent. Each year five of these are appointed to serve for three years. Naturally, the men holding these positions are usually from the great teaching centers. They dwell a little apart from the mass of physicians; their viewpoint is necessarily not just that of the man whose career is centered on practice, not education.

Dr. Burgess coming from a progressive community, but one well away from a medical school, will supplement and broaden the services of these leaders of the profession. His work among us has shown how well equipped he is to do his part. We are pleased that our community can contribute so much to the work of the American College of Physicians.

ANNUAL MEETING

Once again our Annual Meeting can be described by that much abused American slogan, "Bigger and Better." When we arrived a bit late at the opening of the meeting, several dozen members were standing in the rear, and there was one empty seat in the entire hall. We were about to take this when we realized that if we did the visiting speaker would have no place to go at the conclusion of his address. Many late applicants were unable to get reservations for the Annual Dinner. Every niche and cranny on the three floors of the Library were filled with the technical exhibits. So much for the bigness.

It would really be unfair to say that this meeting was better than its immediate predecessors, but it is saying a lot when we note that it maintained the high standard to which we are now accustomed. In one respect there was a decided improvement. The Chapin Oration was delivered at the scientific session in the afternoon, and the delightful ceremony of the presentation of the medal given by the City of Providence, took place as part of the postprandial exercises at the hotel. Mr. Frederick S. Barnes of the City Council was signally graceful in his presentation speech.

Before this, Governor Pastore addressed us. The highlight of his talk was his discussion of the Medical Examiner problem in Rhode Island and his pledge of help in improving the present unsatisfactory setup. The members of the Rhode Island Medical Society have been greatly impressed by Governor Pastore's understanding of some of our problems and his sympathetic desire to help us solve them.

Although out-of-town physicians from even as far away as Dixieland predominated on the program, Drs. Fulton, Hamlin and Pitts demonstrated ably that instruction and inspiration could come from our own ranks. We congratulate Dr. Pitts on a year of great achievement culminating in a wonderfully satisfactory Annual Meeting, and we look forward to another similar year under the leadership which Dr. Ruggles has long shown us he can give.

WHEREAS, The articles entitled "Your Health" written by Dr. Peter Pineo Chase and published in local newspapers, have received well-deserved praise from the medical profession and the laity alike.

WHEREAS, These essays, together with the question and answer columns, have been composed in easily comprehended language, often compared with conditions well understood by the reader and characterized by a dry humor which has made them both interesting and readable.

WHEREAS, This column is of great value in assisting the educational work of the Rhode Island Medical Society in making disease and its treatment more easily understood by the layman.

THEREFORE, BE IT RESOLVED, That the Rhode Island Medical Society express its approval of these articles and its hope that Dr. Chase will continue the educational program so auspiciously begun.

—Adopted by the House of Delegates of the Rhode Island Medical Society, May 7, 1947

"HOME TOWN" MEDICAL CARE FOR THE VETERAN

In the fall of 1946 a committee of the Rhode Island Medical Society began its conferences to formulate a fee schedule to be the basis for a contract between the Veterans Administration and our Society for out-patient care of veterans with service-connected disabilities. This is the "Home Town" plan which has received much publicity with emphasis on free choice of physician by the veteran. It should be made clear, however, that in actual practice the veteran will have no choice of physician except under unusual circumstances. In Rhode Island veterans must go to the existing V.A. facilities for treatment. This matter became an issue between the Ohio State Medical Society and the Veterans Administration, and as a result it was made clear by General Bradley that veterans must go to such facilities except when it might be impossible for exceptional reasons. It is not our purpose to quarrel with this policy. It has merit. Hospitals and clinics that have been set up at great cost, are well-equipped and staffed by competent physicians should be utilized as a matter of economy if for no other reason. We do oppose, however, misleading publicity. If there is, in general, to be no free choice of physician it should be so stated with all reasonable defense of such a policy.

The Committee of the Rhode Island Medical Society prepared a fee schedule with considerable thought and with conscientious effort to make it fair, reasonable and in accord with fees charged the average patient in this community for similar services. This fee-schedule was submitted to the House of Delegates at its January meeting. It was approved by this body and forwarded to the Veterans Administration which refused to approve any fees which exceeded the maximum allowed by the V.A. fee schedule. In other words, although the Rhode Island Medical Society had been asked to prepare a fee schedule, such a schedule would be acceptable to the V.A. only if it conformed to one already prepared, presumably by authorities in Washington. Under the circumstances one naturally wonders why such a request was ever made to the Rhode Island Medical Society.

Moreover, the authorities propose to set up a fee schedule which shall be uniform and apply to every section of this great country of ours. This is a mistaken policy since it fails to take into consideration the necessary and inescapable differences in fees which result from the difference in overhead expenses of physicians in varying sections of the country. Obviously, a physician in a large city, with heavy expenses, cannot afford to offer services for the same fee which might be adequate to a physician practicing in a small town in rural areas.

Other state medical societies are presently engaged in a controversy with the V.A. in regard to fees. In the Erie County Medical Bulletin, which is published by the Medical Society of the County of Erie and the Buffalo Academy of Medicine, this controversy is discussed in detail. That society had a fee schedule in force which had been accepted by the V.A. It has now been asked by the Veterans Administration to amend it so that it will conform to the fee schedule devised by the Washington authorities. "The Medical Society of the County of Erie intends to defend with every honorable means at its command the existing medical care fee schedule," in the state of New York, "as being in the best interest of veterans as a group."

Within a few days the Secretary of the Rhode Island Medical Society has received a copy of a communication to General Hawley signed by the Presidents of the Colorado, Montana, New Mexico, Utah, and Wyoming State Medical Societies. A paragraph from that communication is quoted:

> "The undersigned officers of the state medical societies and associations of the Rocky Mountain States are therefore shocked to have received within recent weeks evidence of a complete reversal of the previous announced policy of the administration which recognized necessary regional differences in fee levels. There have been presented to the contracting bodies in these states so-called maximum fee schedules reputedly prepared in your Washington offices, and sent to the contracting states with letters to the effect that existing schedules must be revised so that all fees currently above these newly stated maximums must be reduced to that level but that no fees lower than these maximums may be increased. Such action was obviously taken without any previous consultation with the organized bodies representing the medical profession and without any consideration of the problems of practice within the areas concerned. It is the considered opinion of each of the undersigned that this new policy will completely wreck the home town plan for the care of veterans with service connected disabilities in the Rocky Mountain Region. We are not prepared to comment upon its effect elsewhere in the nation other than to emphasize that it is obviously unfair.
>
> "It is the earnest hope of the undersigned that the recent action has been taken by some branch of your administration through misunderstanding and that we may soon have an authoritative statement clarifying this situation and again recognizing existing differences in fee levels throughout the varied regions of the United States."

We feel that this policy of the V.A. should be brought to the attention of all members of the

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Rhode Island Medical Society who should give it their very thoughtful consideration.

Those who understand medical problems realize the great importance of finding solutions to problems which differ according to local situations. They realize the fallacy of attempting to set up complete uniformity throughout this great country of ours. The V.A. should realize that the membership of the Rhode Island Medical Society, and all state medical societies throughout the United States, is made up of a body of useful, intelligent, trustworthy citizens. The physicians of the United States are interested in governmental economy. They are just as much appalled by federal spending as any other citizen, since they are also tax payers. They realize, however, the serious mistake which unwise economy in medicine can be. They know that there is but one inevitable result of the payment of inadequate fees, and that is a lowering of the quality of medical care. The opinions of physicians should receive at least equal consideration, if not greater consideration, than the opinions of perhaps well-intentioned but misguided reformers and those bureaucrats who can never free themselves of the constant thinking in terms of jobs and political expediency.

The physicians of the Rhode Island Medical Society are interested in the welfare of veterans also, since a large number of them are veterans of the most recent World War and World War I as well. And a large number of them, in addition, have sons and even daughters who are veterans and whose welfare is a matter of great concern to them.

This type of medical care of veterans is indeed a form of state medicine. Here is an example to teach us what we can expect under such a system. Apparently officials in Washington will not hesitate to break contracts, and to dictate in an arbitrary fashion, to put in force impractical and unwise policies, and ultimately to destroy the morale of physicians and to lower the level of excellence of medical practice in this country.

"To everything there is a season, and a time to every purpose under the heaven." Now is the time for physicians throughout this country to oppose such arbitrary, unwise, and impractical policies, and to join in full cooperation in opposition to the menace of dictatorship.



Mrs. Jesse P. Eddy, 3rd, treasurer; Mrs. Herbert E. Harris, president; Mrs. Guy W. Wells, vice-president, and Mrs. Charles L. Farrell, secretary, (left to right) after their election at the annual meeting as officers of the Woman's Auxiliary to the Rhode Island Medical Society.

WOMAN'S AUXILIARY TO THE RHODE ISLAND MEDICAL SOCIETY

— Report of First Annual Meeting —

THE FIRST ANNUAL LUNCHEON meeting of the Woman's Auxiliary to the Rhode Island Medical Society was held on May 5, 1947, at the Plantations Club. Mrs. Herbert E. Harris, president of the Auxiliary, called the meeting to order at 1:00 p. m.

Dr. Herman C. Pitts, president of the Rhode Island Medical Society, was the first speaker. Dr. Pitts said that there should be better acquaintanceship among the wives of men who are trying to guide medicine in Rhode Island. He also hoped that we would help guide public opinion, and aid the medical profession in accomplishing its objectives.

Mr. John E. Farrell, executive secretary of the Rhode Island Medical Society, the next speaker, said he was looking forward to a great deal of support from the Woman's Auxiliary.

Mrs. James R. Miller, president of the Connecticut Woman's Auxiliary, extended greetings from Connecticut.

Mrs. David Allman, first vice-president of the Woman's Auxiliary to the American Medical Association and chairman of the National Auxiliary organization, spoke on the work of the Woman's groups throughout the country. She welcomed the Rhode Island Auxiliary into the National Society.

Following a delightful luncheon, a business meeting was held.

Mrs. Charles L. Farrell, secretary, read the minutes of the previous meeting. Mrs. Francis Hanley moved that the report be accepted as read. Mrs. Thomas Dolan seconded the motion. The motion was carried.

Mrs. Jesse P. Eddy, III, treasurer, reported that there was a balance on hand of $450.00. Mrs. Robert T. Henry moved that this report be accepted. It was seconded by Mrs. Marden G. Platt, and the motion was carried.

The Vice-President, Mrs. Guy W. Wells, gave her report. Mrs. Marden G. Platt moved that the report be accepted. The motion was seconded by Mrs. William S. Nerone.

The vice-president took the chair, and Mrs. Herbert E. Harris, president, read her report. It was moved by Mrs. Frank M. Adams, and seconded by Mrs. Frank Dimmitt, that the report be accepted. The motion was carried.

The president resumed the chair.

Mrs. Thomas Dolan, chairman of the Nominating Committee, reported for her committee. The Nominating Committee had been instructed at the previous meeting to present as its slate of candidates the temporary officers of the Auxiliary, and its temporary Board of Directors. The secretary read the names of the officers and Board of Directors now in office.

The president stated that the Convention of the Woman's Auxiliary to the American Medical Association would be held in Atlantic City from June 8-12. She asked the members to elect delegates to the Convention from those planning to attend. One delegate could be elected for each 100 members or fraction thereof, and inasmuch as the Auxiliary has 176 members, two delegates besides the president should be elected.

A motion was made by Mrs. J. Murray Beadsley to accept the first two nominees with the greatest number of votes as delegates, and the next three as alternates. This motion was seconded by Mrs. Paul Cook. The motion was carried.

Mrs. Charles F. Gormly reported for the tellers as follows: Mrs. Charles Ashworth, 38 votes; Mrs. Charles L. Farrell, 35 votes; Mrs. Francesco Ronchese, 33 votes; Mrs. Jesse P. Eddy, III, 22 votes; and Mrs. Henry V. Moor, 18 votes.

Mrs. Charles Ashworth and Mrs. Charles L. Farrell were elected delegates. Mrs. Francesco Ronchese, Mrs. Jesse P. Eddy, III and Mrs. Henry V. Moor were elected as alternates.

The president then asked for nominations of candidates for the Nominating Committee for the next annual meeting. She also informed the members that the Constitution required that two members be elected from the Board of Directors and five members from the floor.

The following candidates were nominated: Mrs. Paul Cook, Mrs. Earl Mara, Mrs. Russell Hunt, Mrs. Elihu Wing, Mrs. J. Murray Beardsley, Mrs. Francis Hanley and Mrs. George Waterman.

It was voted to close the nominations.

The president then asked that the motion to close the nominations be rescinded in order to permit further nominations from the various districts of the State.

Mrs. Russell Hunt voted to rescind the motion

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AMEBIASIS IN A RHODE ISLAND CHILD*

HERMAN B. MARKS, M.D.

The Author. *Herman B. Marks, M.D., of Providence. Member, Visiting Staff, Department of Pediatrics, Rhode Island Hospital; Consulting staff, Emma Pendleton Bradley Home; Assistant Medical Director, Providence Child Guidance Clinic.*

AMEBIC DYSENTERY is presumably a rare disease in Rhode Island. The following review represents the first known reported case of amebiasis in a child in this state and seems, therefore worthy of report. While the disease has occurred only sporadically in Rhode Island, we may expect that cases will be reported more frequently in the next few years. The return of veterans from war zones where the disease is endemic and the practice of importing into the state domestic help from the Southern States and from Puerto Rico should serve as a reminder to include this disease in the differential diagnosis of any ill defined chronic gastrointestinal disturbance.[1]

Amebic dysentery has been reported in every state and should by no means be considered as strictly a tropical disease. Estimates as to the incidence of Endamaeba histolytica infections in the general population of the United States range from ten per cent by Craig[2] to twenty per cent by Faust[3] of the total population. It has been said: "Amebiasis is a common disease in the South." "Other surveys have suggested that it is only less common in the North and West as well."[4]

How much amebic dystentery have we had in Rhode Island? To answer this question a check was made of the records of:

1. State Division of Communicable Diseases.
2. Health Department of the City of Providence.
3. The Laboratories of the State and of the Veteran's Administration in Providence.
4. Five hospitals—Rhode Island Hospital; St. Joseph's Hospital; Charles V. Chapin Hospital; Homeopathic Hospital; Memorial Hospital, Pawtucket, Rhode Island

It was felt that a study of the records of the above listed institutions and departments would give a fairly representative picture of the incidence of amebic dysentery in this state. A total of twelve cases were discovered. The following table shows the incidence from year to year.

Year	*No. of cases*
1929	1
1931	1
1933	2
1934	3
1940	1
1945	1
1946	3

If one were to draw any conclusion from these figures, it would be that we have very little amebiasis in Rhode Island. These figures do not coincide very well with the previously quoted incidence of 10 to 20% for the general population. It should be emphasized that 76.2% of all cases are totally asymptomatic carriers and that careful fecal examinations would probably reveal a higher incidence of cases. Writing on the amebiasis problem, Craig[5] states dogmatically: "Routine fecal examinations are probably more important than routine blood examinations." While we might theoretically argue the relative merits of routine blood examinations vs. routine fecal studies, no one would disagree with Craig when he says, "If such routine examinations were properly made, more cases would be picked up and eliminated if properly treated." Since the great majority of infections in this country are acquired through food handlers, any rational approach to this problem should require careful stool studies for asymptomatic amebiasis in individuals so employed.

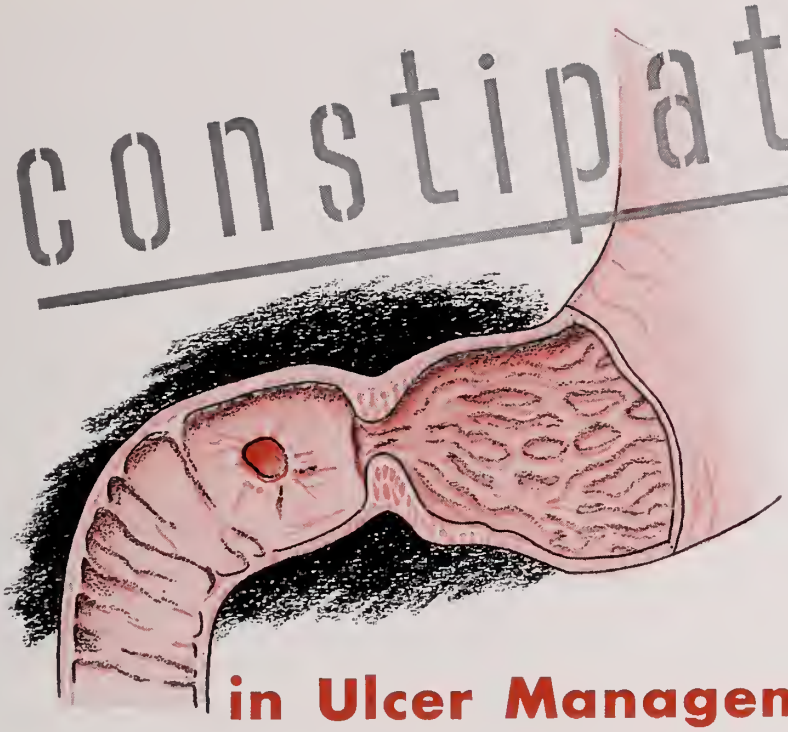
Case Report

The patient is a 4½ years female child. Her symptoms began in December 1943 when she was 16 months old. The parents dated the onset of her symptoms from an episode which happened about that time. She was left alone with a baby watcher and when the parents returned a large black and blue mark was noticed on the bridge of the child's nose. How the child received this injury was never satsfactorily explained. It was shortly after this incident that the little girl began to have severe night terrors, 2 to 3 times every night. These night terrors would begin with grinding of the teeth and would culminate in loud screaming which her parents were unable to control. At about this time, she began to vomit frequently. Vomiting would

continued on page 444

* From the Providence Child Guidance Clinic and the Emma Pendleton Bradley Home.

constipation



in Ulcer Management . . .

"Constipation is not an important **symptom** of ulcer, but is often the outstanding **complaint.** Many patients either disregard the 'indigestion,' distress or pain . . . Such patients frequently become established cathartic addicts, with resultant bowel dysfunction and abdominal discomfort to confuse the distress picture."

—Portis, S. A.: Diseases of the Digestive System, ed. 2, Philadelphia, Lea & Febiger, 1944, p. 199.

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SEARLE *RESEARCH IN THE SERVICE OF MEDICINE*

AMEBIASIS IN A RHODE ISLAND CHILD

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occur during or after a meal. It was at this time the mother noted small amounts of blood in the stool on several occasions. In April 1945, when she was 2½ years old, the child began to have very loose bowel movements. The stools would vary in number from 2 to 4 daily and were at times explosive in character. There were periods of no diarrhea during which the child would have very large formed stools which were unusually foul smelling. Along with the onset of the diarrhea, she began to have abdominal pain. She was treated with atropine which seemed to relieve the pain, but the diarrhea became worse.

By the time the patient was 2½ years old she had become an irritable child. This irritability became a constant feature of her personality pattern. She had to be removed from a nursery school because of her frequent vomiting. During the last 3 months—that is, October, November, December 1945—her vomiting, night terrors and irritability had become much worse. All attempts to discipline the patient had been ineffective.

The family consisted of the patient, her baby brother who was 2½ years younger, and her parents. The parents were young, intelligent, and cooperative. They were somewhat overwhelmed and discouraged by the persistence of their daughter's symptoms despite prolonged and very adequate medical study.

In December 1945 the patient was carefully studied in a children's hospital outside of Rhode Island. After a complete work up including G.I. series and intravenous pyelograms no organic factor could be found to explain the symptoms and the following diagnosis was made. "Behavior Problem with Emotional Instability 043-x72." It was recommended that the child should be seen by a child psychiatrist. Accordingly, the patient was referred to the Providence Child Guidance Clinic where she was started in therapeutic interviews on a weekly schedule.

In March 1946, I examined the patient for the first time because of a mild upper respiratory infection. The striking sign on physical examination was a markedly distended abdomen which was in marked contrast to the spindly arms and legs. These physical findings together with the history, of a chronic intestinal disturbance, large foul smelling stools, alternating with diarrheal stools, the picture of prolonged irritability,—all seemed to fit with the symptom complex of coeliac disease.

The following day, a stool specimen was examined for microscopic fat. No excessive amounts of fat globules were found. However, on microscopic study an unusual number of red blood cells were noted. This prompted further study and several cells were seen which looked suspiciously like trophozoite forms of Endamoeba histolytica. Several of these showed ingested erythrocytes.

During the next few days a series of fresh stool specimens were studied. Motile vegetative forms of Endamoeba histolytica were found. In 3 consecutive stools, using the zinc sulphate flotation technique, encysted forms, clearly differentiated from Endamoeba coli were demonstrated. It was therefore concluded that a diagnosis of Amebiasis was established and specific treatment should be instituted.

The patient was started on Tablets Chinioform 0.25 gms. t.i.d. This treatment was kept up for 10 days. Within 72 hours after instituting treatment there developed a most dramatic improvement. The night terrors disappeared; there was no further diarrhea. For the first time in many months, the child began to display vigor in her play. Her appetite improved, her irritability lessened, and she began to gain weight. Her abdomen remained distended. This consistent improvement continued through the next six months. She gradually gained weight and strength. It was some source of satisfaction to the parents that for the first time in her life this child was strong enough to pedal a bicycle.

Throughout this period, the patient and her mother made regular visits to the Providence Child Guidance Clinic. From almost her first interview, this child presented a picture of an emotionally disturbed girl with many difficulties in her relationship with her parents and her younger brother. The rapidity with which this child became involved in a relationship with the therapist and the intensity of this relationship was an indication of the extent of her emotional disturbance. In a long series of play interviews, she utilized this relationship to project her feelings about herself, her parents and her brother. As she brought her aggressive and hostile feelings to the surface in the presence of a sympathetic and supporting adult, many of her anxieties were dissipated. A very subtle but definite improvement in behavior was observed by both parents and clinic staff. This change in personality pattern is not too well delineated in this case report, but it was very real to those who followed this child's progress from week to week over the course of several months.

In November 1946, there was a slight recurrence of diarrhea and the patient was noted to be somewhat irritable. Physical examination was negative except for a mild degree of abdominal distention. Laboratory studies showed a mild degree of secondary anemia (Hemoglobin 10.5gm.). Stools were negative for trophozoites and cysts. She was given another course of treatment. This time, tak-

continued on page 446



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1. Editorial: J. A. M. A. 127:1056, 1945
2. Moore, et al: J. Clin. Investigation 23.547, 1944
3. Reznikoff and Goebel: J. Clin. Investigation 16:547, 1937

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ing Tab. Diadoquine gr. 3.2 b.i.d. for a period of 3 weeks. The mild symptoms disappeared, her appetite improved and her steady weight gain continued.

During the past year except for mild whooping cough and chicken pox she has enjoyed excellent health. She attends nursery school and is a healthy happy child.

DISCUSSION

Although there was dramatic improvement in the patient's behavior following specific treatment for the amebiasis, it became quite apparent, as the interviews progressed, that this child's physical illness and emotional problems were interrelated—and to treat one phase of her illness and to neglect the other would not have produced the end result that we sought to achieve—a physically healthy, emotionally well integrated little girl. It is an accepted fact that physical disease can adversely affect the personality pattern of an individual and conversely, it is equally true that emotional maladjustment can accentuate somatic complaints. During the past 2 decades, these concepts have grown into the science of psychosomatic medicine. Obviously, had this child received psychotherapy alone (as was originally planned) her symptoms would have continued. Conversely, to have treated the amebiasis without giving consideration to the emotional conflicts that were engendered in both parent and child by this chronic disability would not have resulted in the complete and satisfactory results which were achieved.

The psycho-therapeutic aspects of this case are too complex to be reviewed in detail in this report. Suffice it to say, that the dynamic factors involved were not at all minimal. They colored the child's symptoms to a great extent and grew out in large measure from the fact that she was physically ill over so long a period.

The source of the infection has never been satisfactorily explained. It is known that there has been a series of maids in the home. One of these may have been a carrier. It is also known that the patient visited her grandparents, who live in the South, several times before the symptoms began. Stool examinations of the parents have been reported as negative.

It is noteworthy that the patient presented so many of the clinical features of the celiac syndrome. True celiac disease is relatively rare and many chronic gastro-intestinal disturbances in children of diverse etiology may simulate it. Chronic-intestinal allergies, parasitic infestations (including amebiasis), diseases of the pancreas—such as fibrocystic disease are but a few of the factors that may produce a clinical syndrome that may resemble celiac disease.[6] In fact celiac disease was the clinical impression which first suggested itself in this case and it was a search for fat globules in the stools (a now outmoded laboratory procedure) which led to the accidental finding of the vegetative forms of Endamoeba histolytica. This fortuitous accident emphasizes the value of careful routine stool examinations.

Summary

Amebiasis does occur in Rhode Island. Careful stool examinations performed more frequently would probably reveal a greater number of cases than are now being reported. The case presented is thought to be the first known case of amebiasis in a child in this state. Treatment involved not only eliminating the protozoa from the patient's gastro-intestinal tract but also, and equally important, was concerned with the improving of the faulty parent-child relationship brought on by this chronic disability.

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Acknowledgments

1. Dr. Gertrude Muller, Medical Director of the Providence Child Guidance Clinic supervised the psychotherapy of this case.
2. Dr. Eric Denhoff, Director, Clinical Laboratory, Emma Pendleton Bradley Home aided in confirming the laboratory diagnosis of Endamaeba histolytica. All laboratory studies were made at the Clinical Laboratory of the Bradley Home.

CONGRESS ON OBSTETRICS AND GYNECOLOGY

The third American Congress on Obstetrics and Gynecology will be held at the St. Louis Municipal Auditorium, September 8-12. Physicians desiring to apply for membership should file requests now with the American Committee on Maternal Welfare, Inc., 24 West Ohio Street, Chicago 10, Illinois. The membership fee is five dollars.

The morning sessions of the Congress will be joint gatherings for everyone while the afternoons will be given over to separate group meetings, and round table discussions.

It is the aim of the Congress to provide a meeting that will be of value not only to the obstetric-gynecologic specialists but to those who come in contact with the greatest possible number of maternity cases, the general practitioners. The program will attempt to analyze, correlate and broaden the working contact of the doctor, the obstetric nurse, and the public health worker.



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— THE ANNUAL DINNER —

136th Annual Meeting of the Rhode Island Medical Society

May 14, 1947

Frank T. Fulton, M.D., *Presiding*

Anniversary Dinner Chairman

Your Excellency, Governor Pastore, Honorable Frederick S. Barnes, Distinguished Guests, Fellows of the Rhode Island Medical Society, and your Guests:

A part of our program tonight is to pay tribute to the name of one of the great men of our profession, a native of Rhode Island, a man not long since dead, but who has left a name that we all like to honor. Dr. Chapin finished his medical education and his hospital training in New York in 1880, came to Providence and engaged in practice for four years, then became health officer in the City of Providence, a position which he held until his resignation in 1932, a period of 48 years—a long time for any public health officeholder. He was so far ahead of his time in his ideas concerning contagious disease that for years he was not particularly happy in his work, because of lack of co-operation both of the public and the medical profession. It was 26 years after he became health officer that the City Hospital was built. I know it was a great satisfaction to him when the City Hospital was completed, where he could put to trial his ideas about contagion. This hospital under his direction soon became recognized as the model hospital for the modern treatment of contagious disease. Because of the distinction which Dr. Chapin had attained, the name of the hospital in 1931 was changed from the City Hospital to that by which you now know it.

Dr. Chapin's contributions benefited not the City alone, but naturally the State shares equally in these benefits which came from his distinguished efforts as a health officer. It is always a pleasure and satisfaction to have the State and City officials present at our functions. We look to them for support in all our efforts to improve the practice of medicine and sanitary affairs. In this Governor Pastore has shown active interest. He has graciously consented to be with us as our guest tonight and will now speak to you.

Honorable John O. Pastore

Governor of the State of Rhode Island

Mr. Toastmaster, Reverend Member of the Clergy, Dr. Bayne-Jones, the recipient of the Award, Officers and members of the Rhode Island Medical Society and their ladies. First of all, I want to apologize for coming in here at a late hour, and not being able to stay to the conclusion of the exercises this evening. As your Toastmaster has already told you, I have been to one banquet, and I have to attend another before I retire tonight.

I am happy to come here tonight to bring the greetings of the State, and also to express to you the gratitude of the people of Rhode Island for the splendid contribution made to the health and well-being of our citizens by the members of this honorable profession. I come, too, to express my personal gratitude to a great number of your members, upon whom I have called from time to time for assistance and guidance, and in consultation, and I am very much elated over the fact that on every occasion I have found the members of this society very cooperative and willing to assist the people of the state in any capacity that they could.

I take this particular occasion to enumerate one or two, particularly Dr. Ruggles and Dr. Donley, who, only a short time ago, served on a Commission that I designated, to make a study of the conditions at the institutions, and at great personal sacrifice to themselves, they undertook this study, together with Mrs. Gould, formerly of the Congress of Parents and Teachers, and within a short time made a very splendid report to me, a report instrumental in making certain changes that have enhanced the situation considerably.

There has always been a strong bond of cooperation and friendship between this organization and the present state administration. We strive and we sincerely intend to keep it just that way.

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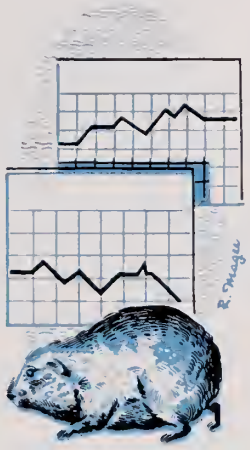
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GOVERNOR JOHN O. PASTORE

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Today, government has become quite a complex thing. Most of you realize and appreciate that, and from time to time, there are many problems that loom up that are of mutual concern to your organization and to the state administration. That is not unusual. There is nothing remarkable about that.

I take particular occasion tonight to mention one problem that has been mentioned, and that has come to the attention of the Rhode Island Medical Society, not too long ago, by way of resolution on the part of the House of Delegates. You saw fit to criticize the system of medical examiners in the State of Rhode Island, and suggested at that time that a Committee be appointed by the Rhode Island Bar Association to make a study of the situation and to determine what could be done about it. I am very sympathetic to that study, and I know whereof I speak. Not too long ago, as some of you probably know, I was in charge of the criminal end of the State of Rhode Island, and had a lot to do with reference to prosecution of criminal cases. I have had great contact with the medical examiners in the State of Rhode Island. I say that while our system of medical examiners in Rhode Island is just as out-moded as our present county jail system, the fact still remains that there are, among the medical examiners, and there are at least four that I know in this room tonight, Dr. Ashworth of Providence, Dr. Magill of Providence, Dr. Randall of Foster, Dr. Abbate of Warwick, men who have served with integrity, and these men have served with ability. But, over and above that, we must realize that Rhode Island is a small state in area. In New York City, for instance, they have what I deem to be an up-to-date system of medical examiners. Not too long ago it was my privilege to go to New York in connection with one of the cases that I was prosecuting. I believe it was the Blood case in Pawtucket. At that time, I had a talk with Dr. Gonzales, Dr. Vance and Dr. Halpern who are stationed or located at the Bellevue Hospital in New York City. They have one focal point, one central point, from which all the medical examinations are made.

True enough, here in Rhode Island, we have a hit-and-miss system that is not the fault of the doctors who serve as medical examiners; it is to be charged up to the system that we have had over a period of years, and no one has seen fit to do anything at all about it. I think it ought to be changed. I think the time has come for a change. We know that there are some localities where it is even hard to appoint, under the requirements of the law, a medical examiner to serve in a particular township. That is only because the doctor who is serving that locality is too busy with his own practice. He hasn't the time. The men whom I have already enumerated to you are very busy practitioners, and they have to drop everything they are doing, when there is any evidence of violence, to review a body. I say that that is not only unfair to the doctors, but it is absolutely unfair to the State as a whole.

I think that some more up-to-date system ought to be worked out. I want the medical association of the State of Rhode Island to realize that insofar as I, at least, am concerned, you shall have all of the cooperation that you desire.

Tonight, in conjunction with your ceremonies, you take occasion to designate and to honor the recipient of the Charles V. Chapin Award. You have chosen Dr. Bayne-Jones. While I have not had the privilege and the honor of meeting him before, I feel that having chosen him, you are selecting a man who is absolutely qualified to receive the award.

Dr. Bayne-Jones, I, as the Governor of the State of Rhode Island, indeed do congratulate you upon this occasion for the members of the association, and for their wives and their friends. I want to assure you that it was pleasant for me to be here.

I have had a good time here tonight, and my only regret is that I must leave now.

Thank you all, very much.

The Dr. Charles V. Chapin Award

TOASTMASTER FULTON: About six years ago Dr. Gormly suggested that there be a Charles V. Chapin Oration delivered at the Annual Meeting of the Rhode Island Medical Society. That was established by the Society. Subsequently, the City established a Charles V. Chapin Memorial Award, to be given yearly to the man who is selected to deliver the Oration. The sixth annual Oration was given this afternoon by Dr. Stanhope Bayne-Jones of New Haven. Dr. Bayne-Jones is Professor of Bacteriology at Yale School of Medicine, President of the Army Epidemiological Board, was formerly Brigadier General, Medical Corps, and Director of the United States of America Typhus Commission. He chose as his subject, "The Control of Typhus Fever". Those of you who heard that oration know that it will rank high with those which have gone before.

I am sorry we have to report to you that the Mayor could not be present tonight. When this

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THE CHARLES V. CHAPIN AWARD

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Award was established, it was pointed out that it should be the duty of the Mayor to present the Award. However, he has sent to us, to act for him, the Honorable Frederick S. Barnes, who is a member of the Committee and also Chairman of that Committee which established this Award. We welcome you, Mr. Barnes, to the 136th Annual Meeting of this Society and I ask you if you will be kind enough to present this Chapin Memorial Award to Dr. Bayne-Jones.

Hon. Frederick S. Barnes

Dr. Charles V. Chapin Memorial Award Committee of the Providence City Council

Dr. Fulton, Chairman, Dr. Bayne-Jones, our honored guest Reverend Dr. Butler of Providence, other distinguished gentlemen on the dias, members of the Rhode Island Medical Society and Providence Medical Association, and friends.

May I extend the apology of Mayor Dennis J. Roberts for his inability to be present on this great occasion. He has asked me to convey to you the greetings of the people of the City of Providence.

I find myself in a rather difficult position because of all the nice things that Governor Pastore has said regarding our honored guest and the members of the medical profession.

However, it is with a great deal of interest that I have noted that the Chapin oration of the day has been given by Dr. Bayne-Jones, and he has addressed you on the "Control of Typhus Fever." There was a day, not so long ago, when such a subject would be out of range of interest for the average American citizen. The World War changed our thinking in such matters, however, as the members of the armed forces, particularly, were immunized against disease as they carried the battle to the remotest jungles of the world, and we are acutely conscious of the great part that medical and public health research has played in guarding our and their lives.

I am sure the veterans of this State have a clearer recognition of the work of Charles V. Chapin, which he carried on for many years in the city of Providence in the face of public criticism and disinterest. His achievements stand forth more clearly to all of us now, and the more fitting it is that the City of Providence should join with the Rhode Island Medical Society and the Providence Medical Association, on this occasion, to pay tribute to Dr. Chapin's memory.

The extent of Dr. Chapin's influence is a matter of conjecture. His work in our city won the praise of the world.

I am thinking of him in another light, that of an individual whose theories and principles may have had far-reaching effects on his colleagues.

In that connection, I recall to your minds that Dr. Chapin was a fellow student, intern and a close friend of the late General William C. Gorgas, while the two were students at Bellevue Hospital in New York City. It remained for Dr. Gorgas to apply the methods of yellow fever control, when our government built the Panama Canal, for without these sanitary measures, the Canal, which was to be the life-line of our armed forces as we carried on a two-ocean war in this decade, could not have been built.

Therefore, as we pay tribute to the memory of Dr. Chapin, we also pay tribute to all physicians whose war with disease never ceases. We pay tribute, particularly, to the present-day leaders in research, such as Dr. Bayne-Jones, in his former position and his position now as Director of the United States of America Typhus Commission.

On the occasion of this, the 136th Annual Meeting of this historical medical society, in behalf of the City of Providence and the Charles V. Chapin Memorial Award Committee of the Providence City Council, I am happy to award you, Dr. Bayne-Jones, this Chapin Medal, in fitting recognition for the contribution that you, sir, have made to humanity, and the things we expect of you gentlemen of the profession.

Stanhope Bayne-Jones, M.D.

Mr. Barnes, Dr. Fulton, Dr. Pitts, Distinguished guests, Friends. I feel deeply moved by the honor given to me, and, as I said today, the people with whom I have the good fortune to be associated share this with me.

This Award symbolizes or puts in the form of unending treasure and memory a recognition of preventive medicine that seems to me must be deep in the hearts of all people, physicians and civilians, not only in this room, but in this town, realizing that in the ideas of preventive medicine that Dr. Chapin had, there was, perhaps, the great salvation.

I am a southerner, from Louisiana, who had medical forebears about the time of Dr. Chapin's regime in Rhode Island. My grandfather fought

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STANHOPE BAYNE-JONES, M.D.

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the battles for public health, as he did. My grandfather wrote great, long books and things about bacteria, in relation to disease. I didn't know until I came up into this region that you could say all of that in the Chapinesque style that was very short and very brief, and very much to the point. His paper, in 1885, about the status of the germ theory of disease at about the time when Dr. Welch and others were getting busy, says to the people of Rhode Island and elsewhere: "You have heard a good deal about what Pasteur and the other Europeans have been doing, but it has come to you from abroad and is hardly believable. But, I want to tell you that I have looked into it a little bit, and germs do cause disease." And then in short and in authoritative language, he tells that there is a transmission of disease by microbes and concludes that they should do something about it, instead of getting rid of bad smells and dirty ash heaps.

He represents a type of the fighting preventive medicine officer of that time, like one or two others I have known, who stood strongly in their convictions and who survived every possible change in administration around them, and who had the highest ideals and who were constantly growing with the situation, learning and leading.

I think that this is the greatest honor that could come to one who has been a follower of Dr. Chapin's and striving to do something akin to the level of his ideals.

I thank you with my deep gratitude.



Providence Journal Photo

Councilman Frederic C. Barnes, representing Mayor Dennis J. Roberts, presents the Dr. Charles V. Chapin Award of the City of Providence to Dr. Stanhope Bayne-Jones, of New Haven (second from right), at the 136th Annual Meeting of the Rhode Island Medical Society. Observing the ceremony are Dr. Herman C. Pitts (left), president of the Society, and Dr. Frank T. Fulton, anniversary dinner chairman.

Presentation of Gavel to H. C. Pitts, M.D.

TOASTMASTER FULTON: At this stage in the program I hope I may be pardoned if I indulge in some personalities. These reminiscences, while trivial, will serve to illustrate how marked changes come along almost imperceptibly.

I came to Providence forty-seven years ago this coming July, as Pathologist to the Rhode Island Hospital. At that time there was in the laboratory, among other things, one microscope. There was in the possession of the hospital one outfit for blood counting. The devices for measuring the blood pressure, other than by the tip of the finger, had not been invented, nor were they in use for several years. I am told there are now 26 microscopes in daily use, and that many individuals using them. Blood examinations amounted to 3740 in a recent month and in a recent year to 38,600. Blood pressure readings are taken almost as commonly as temperature and pulse. I am quite sure that no one in Rhode Island had had either the courage or the curiosity to puncture a vein with a hollow needle and I am also quite sure that I did that first, myself. Now, all of you know that that procedure is followed every day and many times a day at the hospital, either to withdraw blood for diagnosis or to give treatment.

About a year after I came, Dr. Pitts came to the hospital as an Intern. There were 8 Interns who lived in what was called, "Intern Alley", and I lived with them. We were all good friends and most of us were good workers. I might say by way of parenthesis that there are now 20 Interns and upward of 20 Residents. Dr. Pitts spent quite a little time as a voluntary worker in the Pathological Laboratory. I soon recognized him to be industrious, intelligent, aggressive, progressive and venturesome—characteristics which he still retains, and we became intimate friends. I did note this last year signs of timidity when I had trouble in persuading him to fly across the Gulf of Mexico with me. When his internship had terminated, we, together, left the hospital for other living quarters and settled at the corner of Angell and Thayer Streets in a 100-year-old house which had been moved from somewhere else to that place. There we had offices, diagonally across from Anthony's Drug Store. Our arrival caused one man to make a remark which was later repeated to me: "There are

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PRESENTATION TO HERMAN C. PITTS, M.D.

continued from page 456

two more doctors who have come up here to starve". Who those fellows were that starved, we never did find out. But there was one doctor, still living, which gave us comfort. At that time most of the doctors of consequence were on either Benefit or Broad Streets. My Secretary noted in the telephone book the other day that there are now 182 doctors on Angell and Thayer and Waterman Streets. Dr. Pitts did not starve. Instead of starving during these long intervening years, he has done much to his own credit, to that of the City, the State, to our profession and for the benefit of the community. As President he has given outstanding leadership during the past year. He has served for two years as President of the American Society for the control of Cancer, is now President of the Rhode Island Society for the Control of Cancer. He is a member of the American Society for Cancer Research, a Diplomat of the American Board of Surgeons, a member of the College of Surgeons, and in World War I he was Major and Chief of Surgical Service at Base Hospital 77 in France, and last but not least, he received the Temple Emanu-El Men's Club Award for "outstanding achievement in the field of civic improvement, human betterment and the advancement of American ideals", in 1942.

Dr. Pitts, it gives me great pleasure to be the person who is to present to you this gavel as a souvenir of your Presidency. It is a gift from the members of the Rhode Island Medical Society. It will probably be of little use, as it is an emblem of past authority and not future, but I hope it will be an heirloom which your family may cherish.

Herman C. Pitts, M.D.

President, Rhode Island Medical Society

Thank you, Doctor Fulton. I can assure you that I will cherish this gavel for the rest of my life. My young son is in the Harvard Medical School now, and I trust, will carry on the family tradition of medicine, so that this will always be a prized possession of the Pitts family.

Mr. Anniversary Chairman, Dr. Bayne-Jones, Mr. Barnes, and all these other distinguished gentlemen at this head table. After such a very flowery introduction, I hesitate to get up here and face you all. It requires more courage than I displayed in flying from New Orleans to Guatemala!

The Governor spoke, when he came in, of the remarkable fact that we were able to get so many doctors together in one room. He didn't mention the doctors' wives at all. But as I look around, I can see quite a number of the doctors' wives here present. And this marvelous gathering of you wives gives me a great opportunity to say a few words to you. Your husbands are going to be inflicted with a few remarks from me tomorrow, so that it is quite fitting that you share-and-share-alike with them.

I suppose this evening marks one or two important things in my life. In the first place, it is a sort of swan-song of my presidency of the Rhode Island Medical Society. Tomorrow, the mantle of authority descends to abler shoulders in the person of my very good friend, Dr. Ruggles. It marks, also, the end of a very pleasant year, which has passed very quickly, yes, much more quickly than I dreamed it would when I was elevated to this honor.

The year has been pleasant because of a number of things. The two most important are, first, the fact that I have had the best sort of cooperation from every member of the Society. I see a great many men here present who have taken part, yes, a very enthusiastic part, in running the Society during the past year. It would be impossible to single out these various gentlemen, as I see them before me, but my warmest thanks to them just the same. But, I should like to single out one in particular. Until he was taken ill, he was extremely faithful in making the long trip from Westerly to all of our meetings, and it gives me a great deal of pleasure to introduce a man who doesn't need much introduction truly enough. I refer to our Vice President, Dr. Scanlon. I appreciate your help, Doctor, in getting through a good many of those long and difficult meetings.

The year has been pleasant for another very cogent reason. I refer to the very efficient way in which our Executive Secretary, John Farrell, has taken work off my shoulders. As a matter of fact, I don't see how any President of the Rhode Island Medical Society ever ended a year in good health before Mr. Farrell came to us!

I hope that the cause of medicine has been advanced a little bit during the past year. I can assure you that we have had much discussion, and any one who has attended any of the meetings of the House of Delegates, I am sure, will agree with that. Every year medicine requires more and more from each man in practice, and in consequence,

more and more from each of you wives who has been unfortunate enough, or perhaps fortunate enough, to have married one of us. It is about these added requirements I wish to speak.

As you walked in this evening, I failed to notice any lagging steps, any backward glances as if you weren't quite sure you belonged here. You do belong now in this day and generation, but I can assure you if one of our founder members of 136 years ago could come back tonight, the thing that would astonish him most would be seeing women in a gathering of professional men to do honor to an internationally known scientist come among us to honor another great scientist — our own beloved Dr. Charles V. Chapin.

But perhaps you do not realize that this is a woman's world! It hasn't been such for so many years. Even I can remember when women were kept in a condition of servitude by bustles and heavy skirts that trailed the ground. My memory, fortunately, doesn't go back to hoop skirts!

The change came somewhere in the nineties. It was gradual and not entirely unobserved, for Tom Masson could lament that "Woman has usurped all the prerogatives of man save bi-furcated garments and a sense of humor and these she approximates by diaphonous skirts and a superficiality". Alas, or perhaps not alas, if old Thomas were alive today he would find woman in many positions where a sense of humor is of paramount importance and could probably notice that diaphonous skirts are no longer necessary to reveal their charms!

And by all this emancipation of woman, man has profited. There is never a movement of any importance that is not participated in by women. I speak feelingly when I pay tribute to the excellent work the women of the Field Army have done in spreading cancer education, raising money for the cancer work, and in bringing hope and comfort to the many cancer sufferers.

Medicine, I believe, is at the parting of the ways. One road leads to greater glory in service to mankind through individual effort, through the natural desire of man to excel his neighbor in knowledge and skill. The other road leads to the dead level of mediocrity through control of medical practice by the State. There would be no stir of ambition to excel in the breast of the medical man serving the State for he would know very well that the reward of the dullard would be as great as the reward of the brightest and most conscientious. And the recipient, the worker who has his weekly pay envelope docked to pay for this semi-charity, is the loser in receiving more medicine, perhaps, but just the kind of medicine one would expect from mediocrity — poor medicine. Perhaps worse than that, too, he would lose the desire, the ambition to provide for the hazards of life himself and the "ultimate result of shielding men from the effects of folly is to fill the world with fools".

From every consideration medicine must not be allowed to take this road, and you women can do a tremendous lot to keep it on the right track. Our new association of the wives of doctors in the Auxiliary is the organization through which help can be given. You are strong both collectively and individually. Collectively as a body you can influence legislation. Individually in your women's clubs, at the bridge table, in your churches, in social gatherings, you can have a tremendous effect in moulding public opinion, and "public opinion is stronger than the Legislature, and nearly as strong as the Ten Commandments". Make yourselves familiar with the ideas of some of these well-meaning but misguided people who would turn the clock of medical advance back 50 years. Be our publicity agents. Help us keep medicine going forward continuously on the path of greater service to mankind.

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Providence Journal Photo

Dr. Arthur H. Ruggles (center) receives the gavel as new President of the Rhode Island Medical Society from retiring president, Dr. Herman C. Pitts, as Dr. Joseph C. O'Connell, president-elect observes the ceremony.

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WOMAN'S AUXILIARY

concluded from page 441

and Mrs. James McKendry seconded the motion. The motion was carried.

The following candidates were nominated: Mrs. James O'Brien, Mrs. Martin Grimes, Mrs. Joseph Kent and Mrs. Louis Cerrito.

A motion to close the nominations was made by Mrs. Thomas Nestor and seconded by Mrs. Gustaf Sweet. Carried.

The results of the tellers showed that the following members were elected. From the Board of Directors, Mrs. Stanley Davies received 41 votes and Mrs. Thomas Dolan, 38 votes. From the floor Mrs. Paul Cook received 59 votes, Mrs. Martin Grimes 47, Mrs. Francis Hanley 46, Mrs. George Waterman 44, Mrs. Elihu Wing 38.

Mrs. Roland Hammond, chairman of the Luncheon Committee, was given a rising vote of thanks for her efforts in achieving such an enjoyable luncheon for our first annual meeting.

The meeting adjourned at 4:30 p. m.

Respectfully submitted,

Mary A. Farrell,
Secretary

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The past few years have shown an out of proportion increase in the number of premature infants. This has necessitated drawing plans for a much larger premature department and work should be completed here in another month. This addition will allow for the care of 26 babies in incubators in one unit and a somewhat larger unit for their care after they are able to leave the incubators. A third unit has been provided for the nurses office and a wash room and gown room for the visiting pediatricians. A glassed-in corridor provides for visitors viewing the infants, without coming in contact with them.

Luncheon was served to members of the New England Obstetrical and Gynecological Society on April 30, 1947. About 225 members and guests attended the afternoon meeting held at the Lying-In Hospital. The following papers were presented.

1. Symposium on Rh factor
   (a) William E. Furniss, M.D. Laboratory and Theoretical Aspects
   (b) John G. Walsh, M.D. Clinical Aspects
   (c) Maurice Adelman, M.D. The Pediatric Aspect
2. Congenital Anomalies of the Female Genital Apparatus, Walter S. Jones, M.D.
3. Treatment of Placenta Previa and Separated Placenta, John F. Murphy, M.D.
4. Trends in the Indications for Cesarean Section, Alfred L. Potter, M.D.

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MEETING OF HOUSE OF DELEGATES

Rhode Island Medical Society

May 7, 1947

A REGULAR meeting of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, May 7, 1947. The meeting was called to order by President Herman C. Pitts at 8:10 p. m.

The following members were in attendance:

Rocco Abbate	Albert H. Jackvony
Charles J. Ashworth	Walter S. Jones
Robert Baldridge	Francis King
Philip Batchelder	Louis I. Kramer
Alex M. Burgess	Herman A. Lawson
Peter Pineo Chase	Earl J. Mara
B. Earl Clarke	Edward A. McLaughlin
William P. Davis	John C. Myrick
Donald L. DeNyse	Michael J. O'Connor
H. Lorenzo Emidy	Herman C. Pitts
Charles L. Farrell	Arthur H. Ruggles
David Freedman	Julianna R. Tatum
Henry Hanley	Daniel V. Troppoli
Russell R. Hunt	Frederick A. Webster
G. Edward Crane	Edwin B. O'Reilly
Robert Henry	Guy W. Wells

U. E. Zambarano

Also present were Mr. John E. Farrell, executive secretary, and Mr. Charles Williamson, legal counsel.

In the absence of Dr. Morgan Cutts, secretary, his annual report was read by the Executive Secretary. It was moved and seconded that the report be accepted and filed [See page 470 for Report.]

Report of the Committee on Industrial Health:

In the absence of Dr. Stanley Sprague, chairman of the Committee on Industrial Health, his report with recommendations was submitted by Dr. Charles L. Farrell, member of the Committee. This report contained this specific recommendation:

> That the House of Delegates authorize the Committee on Industrial Health to draft a suggested fee schedule for workmen's compensation benefits, and that such schedule be submitted to the Society for approval before being made public.

Dr. Farrell elaborated on the problem relative to the Workmen's Compensation Act.

After a brief discussion, it was moved that the report of the Committee on Industrial Health be accepted and that the recommendation contained therein be approved. The motion was seconded and adopted.

Report of the Committee on Public Laws:

The Executive Secretary read the report of the Committee on Public Laws for Dr. William H. Foley, chairman of the committee, who was absent. The report included two recommendations:

1. That the House go on record as opposing the passage of the Health Act now before the Assembly in its entirety, and that it recommend the passage of sections of the Act separately in order that closer scrutiny could be given each section by the Assembly.
2. That the House go on record as expressing its desire to be considered in the determination of representation on special consideration to be given the Workmen's Compensation Laws, and that it request the Governor to name a member of the Society to this commission in view of the fact that medical care constitutes the major determination for compensation under these laws.

Dr. Baldridge moved that the report of the Committee be accepted and the recommendations be adopted. The motion was seconded and passed.

Treasurer's Report:

Dr. Charles J. Ashworth, treasurer, submitted his annual report for the year 1946.

Dr. Albert H. Jackvony moved that the annual report of the Treasurer be accepted and placed on file. The motion was seconded and adopted.

Relations with the Veterans Administration:

Dr. Herman A. Lawson, chairman of the Committee on Relations with the U. S. Veterans Administration, reported on the difficulties his Committee had encountered at its conference with the Veterans Administration. He stated that the fee schedule, carefully drafted by the Committee and subsequently approved by the House of Delegates, had been rejected by the Veterans Administration and that his Committee was not desirous of amending the schedule to meet a fee table drafted in Washington.

He stated that the "home town service" for med-

ical care for veterans has not been borne out by the facts in Rhode Island, and that it exists only in emergency cases here. He expressed opposition to the publicity to such service.

Commenting on the fee schedule, he called attention to the action of the House, and reported that the Committee was considerate of all factors in drafting the schedule for the Veterans Administration. He pointed to the fallacy of a uniform fee schedule for the entire country without respect for the variance due to the operating overhead for the physician resident in an urban as compared with a rural area.

He reported that Rhode Island was not alone in this conflict with the VA, for the State of Ohio had had much discussion and comment when the program was established there, and Erie County, New York Medical Society, is presently engaged in a controversy due to the fact that the VA is requesting that their fee schedule be amended to match the one drafted by the national office of the Veterans Administration.

He concluded his summary report by stating that he personally felt that the House of Delegates should oppose the dictation of fees from Washington.

Discussion:

An inquiry was made as to how the fee schedule was drafted, and Dr. Lawson reported that it was patterned after the one drawn in several other states plus consideration of the charges prevailing in Rhode Island. He stated that the important thing was not what the difference in fees might be, but who is to set a fair fee, the society or the Veterans Administration.

Dr. C. L. Farrell stated that since the VA had asked the Society to submit a schedule of fees, and it had done so, that no change should be made. Therefore, he moved that the House of Delegates support the Committee on Relations with the Veterans Administration on the stand that it has taken, and further that the House go on record as requesting the adoption of the fee schedule already approved by it for medical services to veterans. The motion was seconded.

In the discussion of the motion Dr. A. M. Burgess pointed out that the present situation was a decided change from the representations made by General Hawley when he addressed the Society a year ago.

The motion was put to a vote and it was unanimously adopted.

Dr. H. C. Pitts suggested that the Committee on Veterans Affairs might consider a meeting with officers of the American Legion and the Veterans of Foreign Wars to acquaint them with the posi-

continued on next page



HOUSE OF DELEGATES

concluded from preceding page

tion of the Medical Society in this particular problem of medical care for veterans. Dr. Lawson agreed that such a step would be a good one to take if the Veterans Administration does not agree with the policy of the Society. He also suggested that the Society communicate with other medical groups to determine their experience in this matter.

Communication from the Blue Cross:

Dr. Arthur H. Ruggles read a communication to the House addressed to Dr. Herman C. Pitts from the Hospital Service Corporation of Rhode Island suggesting a possible solution to the proposed surgical plan and asking that the communication be brought to the attention of the proper authorities and be given consideration. Dr. Ashworth moved that the communication be laid on the table until the House heard the report of the Surgical Committee. The motion was seconded and adopted.

Surgical Insurance Study Committee:

Dr. Rocco Abbate read a progress report from the Surgical Insurance Study Committee, copy of which was distributed to each member of the House of Delegates. [See page 472.]

There was a brief discussion of the report with members of the Committee answering various inquiries directed by members of the House. The discussion was concluded with a motion by Dr. Walter S. Jones that the House instruct the Committee on Surgical Insurance Study to explore the question further and to report to the House of Delegates at its convenience, and he further moved that the House table the communication from the Blue Cross without answer as to the proposition contained therein. Dr. Mara seconded the motion.

Dr. H. Lorenzo Emidy moved to amend the motion to provide that the communication from the Blue Cross be turned over to the Surgical Study Committee. Dr. Ashworth seconded the amendment. After a brief discussion the amendment to the motion was adopted and the entire motion was adopted as amended.

Dr. Pitts discussed the question of a press release relative to the Surgical Study Committee's report. There was lengthy discussion of this matter by members of the House, the executive secretary and the legal counsel. At the conclusion of the discussion, Dr. Ashworth moved

> "that the press be informed that the Committee on the Surgical Insurance Study had made a progress report which had been received and accepted by the House of Delegates, and that the House had instructed the Committee to continue and explore all possible plans for prepaid surgical insurance by private companies as well as the Blue Cross."

continued on page 469

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HOUSE OF DELEGATES

continued from page 466

The motion was seconded and adopted.

Recommendations from the Council:

1. *Blue Cross Directors:* In the absence of the secretary, the executive secretary reported a recommendation to the House.

He reported that a recommendation of the Council made in January had not been brought to the House of Delegates' meeting in that month. The recommendation was as follows:

> "that the House of Delegates at the proper time re-elect the present members of the Society representing it on the Board of Directors of the Hospital Service Corporation."

Dr. Charles L. Farrell moved to lay the recommendation on the table. The motion was seconded.

There was discussion on the motion by members of the House and Dr. R. R. Hunt summarized it by pointing out that the House must decide whether it wants the men to serve officially or not. Dr. Pitts called for a vote on the motion. The motion was defeated.

Dr. Troppoli moved that the House of Delegates re-elect the seven physicians previously named to serve as directors of the Hospital Service Corporation, and that these representatives continue for the remainder of the current year. The motion was seconded and adopted.

2. The executive secretary presented the following recommendation from the Council:

Council:

> "That the Committee on Publication be omitted as a Standing Committee of the Society, and that an Editorial Board shall be appointed by the Editor-in-chief with the advice and consent of the President of the Society, and that the President, the President-Elect, and the Secretary shall be ex-officio members of the Editorial Board.

The motion was made that the recommendation be adopted. The motion was seconded.

Discussion:

Dr. Ashworth discussed the recommendation and urged the deletion of the provision that the Editorial Board shall be appointed by the Editor "with the advice and consent of the President" on the grounds that such action would hinder the Editor in the discharge of his duties and would not work to the advantage of the Journal. Dr. Farrell stated that if the Society is to have a Journal of value it must have an editor in whom it has full confidence and must give him the privilege of picking his staff of assistants. Dr. Chase discussed the problem and cited the fact that the House now controls the Journal and the Editor, and he expressed the opinion that the authority should remain there or else delegated directly to the Editorial Board or the Publications Committee. He stated that the Editor-in-Chief must have some leeway in assigning his staff, and he pointed out that the Editor and the staff are entirely subservient to the Society.

There was further discussion which was closed with Dr. C. L. Farrell's statement that the recommendation would involve many changes including an amendment to the By-Laws of the Society, and therefore the House should, in his opinion, defeat the motion. Dr. Pitts called for a vote and the motion was unanimously defeated.

3. *Recommendation on Medical Examiners:* The executive secretary submitted the following recommendation from the Council:

> "That the House appoint a committee, and that it request the Rhode Island Bar Association to appoint a committee, and that these committees meet jointly to study and investigate the medical examiner system in Rhode Island, and that they report back to their respective societies with recommendataions."

It was moved, seconded and adopted that the recommendation be accepted.

Dr. Pitts called for nominations for the committee to represent the Rhode Island Medical Society. Dr. C. L. Farrell nominated Dr. William H. Foley; Dr. DeNyse nominated Dr. B. Earl Clarke; Dr. Ruggles nominated Dr. Edward A. McLaughlin. It was moved that the nominations be closed. The motion was seconded and adopted.

It was moved that the three men nominated be elected. The motion was seconded and adopted.

continued on next page

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Dr. B. E. Clarke was delegated chairman of the committee by the President of the Society.

Nominations for Officers and Elected Committees:

Dr. Pitts stated that each member of the House had received a copy of the nominations of the Council for the officers and standing committees of the Society to serve for 1947-1948.

Dr. C. L. Farrell stated that Dr. Sprague, chairman of the Committee on Industrial Health, requested that Dr. Francis Hanley be nominated for the Committee on Industrial Health. After brief discussion Dr. Farrell withdrew his nomination.

It was moved that the standing committees as nominated by the Council be declared elected. The motion was seconded and adopted.

Dr. Louis I. Kramer moved that the slate of officers as submitted by the Council be accepted. The motion was seconded and adopted.

In accordance with a suggestion by the legal counsel, Dr. P. Batchelder moved that the House name Dr. Francis Hanley as an alternate member of the Committee on Industrial Health. The motion was seconded and adopted.

Dr. Earl Mara moved to place in nomination the following committee to serve as the Committee on Publications:

John E. Donley, M.D., *Chairman*
Harold G. Calder, M.D.,
C. S. Dotterer, M.D., of Newport
Peter Erinakes, M.D., West Warwick
Charles J. Ashworth, M.D.
Henry E. Utter, M.D.
H. Lorenzo Emidy, M.D., Woonsocket
Charles L. Farrell, M.D., Pawtucket
John E. Ruisi, M.D., Westerly

Dr. F. King moved the election of this committee as named. The motion was seconded and adopted.

Resolution Regarding Dr. Peter Pineo Chase:

Dr. B. Earl Clarke submitted a resolution drafted by Dr. Roland Hammond as follows:

"WHEREAS, The articles entitled "Your Health" written by Dr. Peter Pineo Chase and published in the local newspapers, have received well-deserved praise from the medical profession and the laity alike,

"WHEREAS, These essays, together with the question and answer columns, have been composed in easily comprehended language, often compared with conditions well understood by the reader and characterized by a dry humor which has made them both interesting and readable,

"WHEREAS, This column is of great value in assisting the educational work of the Rhode Island Medical Society in making disease and its treatment more easily understood by the layman,

"THEREFORE, BE IT RESOLVED, That the Rhode Island Medical Society express its approval of these articles and its hope that Dr. Chase will continue the educational program so auspiciously begun."

Dr. Batchelder moved that the House adopt this resolution. The motion was seconded and unanimously adopted as the House applauded the action.

Miscellaneous Business:

Dr. Pitts reported that no delegate had been assigned to attend the annual meeting of the New Hampshire State Medical Society, and he inquired if any member of the House desired to accept this assignment. There was no acceptance.

The Taft Bill:

Mr. Willamson spoke briefly regarding the Taft Bill now before Congress, and he cited the implications of the Act and the position that organized medicine would probably have to take. Mr. Farrell read a very recent communication from Washington relative to the hearings to start on this legislation May 21.

Group Health and Accident Insurance:

Dr. David Freedman inquired whether the Society had given any consideration to group health and accident insurance for the members of the Society. The executive secretary reported that the Council had authorized the appointment of a committee by the President to make the study. Dr. Mara reported that a plan had been adopted by the Pawtucket Medical Association with the Commercial Casualty Company and that at the present time one-half of the members had joined up.

The meeting adjourned at 11:10 p. m.

Respectfully submitted:

MORGAN CUTTS, M.D.
Secretary

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Approved by A. M. A.

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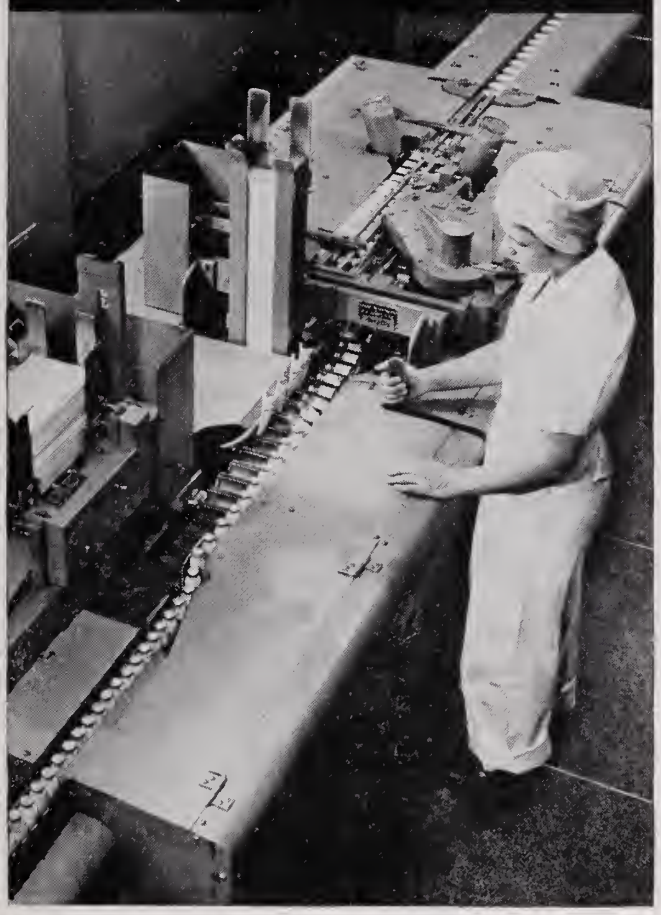
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SURGICAL STUDY COMMITTEE REPORT

At the January meeting of the House of Delegates it was voted that a committee of five members be appointed by the House to study ways and means of putting into effect a Rhode Island Medical Society low-cost prepaid surgical plan as of its own, or through the possibility of having a private insurance company take the plan over.

Recognizing the necessity for activating this new committee as soon as possible, the President of the Society called a special meeting of members of the House present at the mid-winter meeting of the Society on February 3. At that meeting it was agreed that the President should appoint a committee subject to the approval of the House, and that notice should be sent to each Delegate notifying him of the action taken, and allowing him to offer counter nominations. This procedure was pursued, and the committee was officially named in mid-February to consist of the following members:

Drs. Rocco Abbate of Lakewood, chairman, Arcadie Giura of Warren, Charles L. Farrell of Pawtucket, Charles J. Ashworth of Providence, and J. Murray Beardsley of Providence.

At its first meeting the Committee determined that it should first explore group insurance programs now in operation before turning to the consideration of establishing a plan under the complete jurisdiction and administration of the Society. Members of the Committee, together with the President of the Society, attended a conference held in Hartford by the Connecticut State Medical Society at which outstanding insurance executives discussed their participation in prepaid voluntary surgical plans with medical society cooperation.

Subsequently the Committee held a meeting at which the president of the Association of Health and Accident Insurance Companies in Rhode Island outlined the extent to which private insurance could participate in a program such as proposed by the Society.

Although the existence of this new committee of the Society was widely publicized, there has been no request to it from the Blue Cross of Rhode Island for further consideration. Therefore, the Committee can only conclude that the Blue Cross has not altered the stand it took in making it final proposition to the House of Delegates in January.

Meanwhile, studies were carried forward by the Committee of the plans adopted in Wisconsin and in South Dakota where the state medical associations have utilized private insurance to provide low-cost surgical coverage. Complete data on these plans is on file at the executive office, and therefore is not included in this preliminary report to the House of Delegates.

Our next step was to present our Rhode Island proposal to all the group health and accident insurance companies licensed to operate in this state. In a covering letter we carefully noted that we are not requiring one plan, but are seeking a solution to our problem of extending the distribution of low-cost prepaid surgical insurance to the people of Rhode Island, and we are prepared to consider any worthwhile proposal from any one company, or group of companies. The proposal that we submitted included the indemnity schedule previously approved by the House of Delegates, although we realized that this schedule includes the listing of many items that might better be decided by a conference committee once a plan is adopted.

Our proposal to these companies included, in addition to the indemnity schedule of benefits previously approved by the House, policy provisions that we felt should be incorporated in any contract, and also the following general comments:

"Any insurance company licensed to do business in Rhoed Island is invited to submit a plan to provide for payments according to the attached indemnity schedule, or with possible amendments to this schedule, and each company would be expected to include the following provisions:

"1. When the indemnity schedule is finally adopted the contracts must be written without alteration in any respect without approval of the Rhode Island Medical Society.

"2. As a condition for the purchase of the policy there must not be attached any other type of insurance. This does not preclude the inclusion of other phases of health and accident coverage, but does require that only the surgical coverage shall be available to the purchaser without the necessary purchases of other coverage.

"3. An Advisory Committee composed of an equal number of representatives of the Rhode Island Medical Society and of insurance companies underwriting any plan adopted shall consider and resolve all problems arising in the administration of the plan.

"4. Each company agreeing to write the plan adopted shall agree to present a semi-annual report and analysis of its financial and enrollment experiences under the plan to a committee appointed by the Rhode Island Medical Society.

continued on page 475

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SURGICAL STUDY COMMITTEE REPORT

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"5. Each company shall use only such advertising material, report, assignment and other standard forms as approved by the Advisory Committee.

"6. Each company shall properly promote the adopted plan and shall conscientiously endeavor to secure wide coverage among the population of this State."

The re-action to our communication has been excellent. We have received preliminary reports from several companies, and others have asked for further time to study the proposal. Most significant is the fact that the matter is now under advisement by the National Conference Committee on Health Insurance which was organized last year for the purpose of conferring with representatives of the medical profession and hospitals in the development of insurance plans in the health insurance field.

This national committee is composed of representatives of seven trade associations and thus includes representation from substantially all companies writing accident and health insurance in the United States. The Associations are the American Mutual Alliance, the National Fraternal Congress of America, the Bureau of Personal Health and Accident Underwriters Conference, the American Life Convention, the Life Insurance Association of America, and the Association of Casualty and Surety Executives.

Our Committee has planned a meeting for later this month with a sub-committee of this national group to explore our proposal. We hope that this meeting will provide us with sufficient factual information to allow us to make definite recommendations to this House within the next two months.

This report is made to the House at this time mainly that the Delegates may be informed that the Committee has made definite progress in its assignment. The Committee will welcome advice and suggestions from any member of the Society, and it asks the continued support of the House of Delegates in the completion of its study.

Respectfully submitted,

COMMITTEE ON THE STUDY OF PREPAID SURGICAL INSURANCE

Rocco Abbate, M.D.
Charles L. Farrell, M.D.
Charles J. Ashworth, M.D.
J. Murray Beardsley, M.D.
Arcadie Giura, M.D.

May 7, 1947



DISTRICT SOCIETY MEETINGS

WOONSOCKET DISTRICT MEDICAL SOCIETY

The April meeting of the Woonsocket District Medical Society was held on April 15, 1947, at the St. James Hotel in Woonsocket. The meeting was called to order by Dr. Joseph Reilly, President, at 9:30 p. m.

A motion picture film on "Intragastric Drip Therapy of Peptic Ulcer" was shown by representatives of the Wyeth Company. The photography of the interior of a dog's stomach, illustrating experimental ulcer formation, proved to be extremely interesting.

Dr. Reilly presented a letter which he had received from the Rhode Island insurance adjusters suggesting the Society be represented in a discussion of the question of insurance fees for herniorrhaphies. Motion was made by Dr. Joseph McKenna that a committee of three be appointed by the President to comply with this request. The motion was seconded by Dr. Euclide Tremblay and passed by the Society.

The application of Dr. Carlo DeStefani was presented and he was elected to the Society.

The meeting adjourned at 10:55 p. m., and a collation was served. The attendance was twenty-four.

Respectfully submitted,

ALFRED E. KING, M.D.
Secretary

KENT COUNTY MEDICAL SOCIETY

The May 6, 1947, meeting of the Kent County Medical Society was held at the office of the President, Dr. Peter C. Erinakes. There were thirteen members present at the meeting.

The Wyeth Company showed an interesting and practical film on "Post Partum Hemorrhage."

The meeting proper was called to order at 10:00 p. m. The President, Dr. Erinakes, read the minutes of the last meeting, which were accepted after a motion made by Dr. Abbate and seconded by Dr. Mack.

The usual committee of Drs. Taggart, Hudson and Farrell was appointed to make arrangements for the June meeting, which consists of the annual clambake.

Dr. Lamb's name was suggested and accepted to act as Secretary in the absence of the Secretary, Dr. Joseph Harrop. The Secretary was requested, on suggestion of Dr. Taggart, to send a copy of the By-Laws of the Society, with all amendments, to the Rhode Island Medical Society.

The assembly then discussed "Business Affairs," as called for in the Constitution and By-Laws of the Society, Chapter II, Section 3.

These included the discussion of ads or contributions to the different programs and societies, charitable or otherwise.

Dr. Abbate suggested that if the members of the Society contribute to a program, they should make an effort to keep their names anonymous, as required by the ethics of the profession.

The President directed the Secretary to send notices to each member, concerning these contributions, requesting them to keep their names anonymous, if and when they wish to make contributions.

Dr. Mack then suggested that each member contribute towards paying for the luncheon and refreshments so graciously offered the members by the President at the monthly meetings.

M.D. emblems for the cars were then discussed, and it was moved that the matter be taken up with the State Society at an opportune date in the future in order to approach the Registry of Motor Vehicles, and talk over the feasibility of having M.D. added on Doctors' license plates to distinguish the M.D.'s from all the other "Doctors'" shields, which try to imitate the approved A. M. A. emblem.

Dr. Abbate gave a report on the latest steps done to offset Socialized Medicine, and the up-to-date story of the conflict with the Blue Cross, in regard to the "Rhode Island Medical-Surgical Plan."

The meeting adjourned at 11:00 p. m.

Respectfully submitted,

FRANCIS D. LAMB, M.D.
Secretary, Pro-tem

WASHINGTON COUNTY MEDICAL SOCIETY

A regular meeting of the Washington County Medical Society was held at the Westerly Hospital April 9, at 11:30 a. m.

The Secretary reported that no essay had been received in the contest sponsored by the American Association of Physicians and Surgeons.

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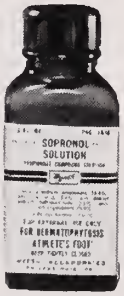
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WASHINGTON COUNTY SOCIETY

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Dr. Tatum presented the proposal of the Rhode Island Medical Society for a state-wide health federation of the public and voluntary non-profit organizations in the State. The Secretary was appointed representative of this society.

Dr. Freeman B. Agnelli gave a very interesting talk on "Streptomycin in the Treatment of Tuberculosis." As a patient in the Fitzsimmons General Hospital of Denver, Colorado, he had a chance to study some of the cases in Project X. His remarks were not for publication for the Army has not yet released a report on the project, but his personal conclusions are that at the present stage of development Streptomycin should be used only when all other therapy has failed.

There was some discussion following, and the meeting adjourned to dine at the Haversham Inn.

Respectfully submitted,

JULIANNA R. TATUM, M.D.
Secretary

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, May 5, 1947. The meeting was called to order by President Guy W. Wells at 8:35 p. m.

The minutes of the previous meeting were read by Dr. Troppoli.

The secretary reported for the Executive Committee as follows:

"That at a recent meeting the Executive Committee had:

"1. Moved that any member of the Providence Medical Association eligible for transfer to the newly formed Bristol County Medical Association shall also be eligible for associate membership in the Providence Medical Association upon application; and further, any Bristol County Association member who has paid the 1947 assessment to the Providence Medical Association shall be refunded the payment.

"2. Moved that the President be authorized to appoint a committee to revive and publicize the prize case report contest along the lines of the contest initiated in 1941.

"3. Authorized the Centennial Committee to engage such clerical assistance as may be needed, and to expend funds at the discretion of the President, the Treasurer, and the Chairman of the Centennial Committee for the proper observance of the Association's centennial in January, 1948.

"4. Referred to the Council of the State Medical Society a study on fees paid by insurance companies for medical examinations and reports."

By a motion from the floor the report of the Executive Committee was accepted and placed on file.

Dr. Wells made the following announcements:

"That on Friday, May 16, at 8:15 p. m., the St. Joseph's Hospital Staff Association will hold its monthly meeting in the Nurses' Auditorium on Peace Street. The speaker will be Dr. James F. Norton, M.D., F.A.C.S., Clinical Professor of Obstetrics, Faculty of Medicine, Columbia University; and Chief of Obstetrics, Margaret Hague Maternity Hospital, Jersey City, and also chief of Obstetrics at St. Mary's and St. Francis Hospitals in Hoboken, New Jersey. Dr. Norton is also Vice-President of the New Jersey State Medical Society.

He stated that all physicians are invited to attend this meeting as guests of the St. Joseph's staff.

Dr. Wells also called to the attention of the members of the Association the fact that the 136th Annual Meeting of the Rhode Island Medical Society would be held at the Medical Library on May 14 and 15.

Dr. Wells reported that the obituary tribute to the late Dr. Salvatore Castallo had been prepared by Dr. Vincent J. Oddo and Dr. Angelo Scorpio, and that it had been filed with the Association for permanent record.

The Secretary reported that the Executive Committee recommended for active membership in the Association the following physicians: Enzo J. Fruggiero, M.D., Herbert F. Hager, M.D., Joseph A. Palumbo, M.D., Richard K. Whipple, M.D.

Dr. William M. Muncy moved that the applicants recommended be elected to active membership. The motion was seconded and unanimously adopted.

Dr. Wells introduced as the first speaker on the scientific program Raymond M. Young, Ph.D., bacteriologist at the Rhode Island Hospital, whose

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PROVIDENCE MEDICAL ASSOCIATION

continued from page 478

topic was "The Newer Knowledge of Viruses."

Virus are divided into two groups, one like bacteria only much smaller and the other non-living enzyme agent. With better microscopes they can now be seen equally. Small-pox virus can be seen multiplying by fission; they are about 10-30 millimicrons in size, a size that approaches that of the larger molecules.

Virus may be produced in tissues when proper stimulation is applied. The stimulation may be chemical or a toxin of abnormal metabolism.

Epidemiology of Virus Infection.

Mumps, chickenpox, and encephatitis are disseminated by droplet infection. Poliomyelitis is now said to be transmitted through the alimentary tract, thence to sympathetics to medulla. The presence of polio virus in sewage is a potential source of infection.

Infectious hepatitis is also transmitted through the stools. Insects also transmit some virus agents. Between epidemics virus live in intermediate hosts. Hemoagglitination tests taken at onset of disease and during convalescent phase and compared show increase in antibodies during the convalescent phase. The compliment fixation test is well adapted to the diagnosis of virus infection. Skin tests are not very good in diagnosis of virus infections, the Frie test in lymphogranuloma venereum is an example.

Prophylaxis and Therapy.

These agents are refractory to antibiotic drugs; Psittacosis and lymphogranuloma venereum are said to respond to sulfa drugs. In many cases attenuated virus gives protection e.g., Rabies. The more viable the virus the greater the degree of protection. Treated yellow fever virus is now safe for human immunization. Pooled serum is useful in measles, mumps and polio.

The second speaker was Dr. Russell S. Bray, physician and Director of the Gastro-Intestinal Department, Rhode Island Hospital, who spoke on "Clinical Aspects of Certain Functional Disorders of the Biliary Tract."

The basic physiological change seems to be an impediment to the flow of bile from the liver to the duodenum. Functional disturbance can cause obstruction, usually at the Sphincter of Oddi due to simple spasm.

Gall Bladder colic can occur without stone or disease and is due to hypertonic contraction of the gall bladder against a spastic sphincter.

Stasis of the gall bladder with distension can cause symptoms of cholecystitis and bring about a favorable environment for development of calculi and changes in the mucosa. Other hollow viscera which are innervated by the same nerves can produce symptoms which may confuse one.

Many cholecystectomized patients show midepigastric pain, left costal border pain, flatulence epigastric fullness, etc. Nerves, marital difficulty, nervous tension bring on attacks. Cholecystography and non-surgical bile drainage is used to study these patients.

In non-cholecystectomized patients all showed delayed evacuation after a fatty meal. Minor pathological changes exist even when the dye is well concentrated. Bile from cholecystectomized patients showed concentration. A constant finding in all cases was precipitated cholestrol crystals during an attack, none during an asymptomatic period. Because of this, biliary cholesterosis is a better term than biliary stasis. Therapy in these cases consists in avoiding overeating, giving small frequent feedings and giving dehydrocholic acid to help bile flow. Also, there is great benefit from gall bladder drainage. Anti-spasnodics also help. There is no constant relationship between the severity of the symptoms and the pathology in the gall tract.

Attendance: 71.

Collation was served.

The meeting adjourned at 9:55 p. m.

Respectfully submitted,

DANIEL V. TROPPOLI, M.D.
Secretary

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held at 9:00 p. m. April 17, 1947, in the Nurses' Auditorium of the Memorial Hospital. Twenty members attended.

The meeting was called to order by the President, Dr. Earl J. Mara. The minutes of the previous meeting were read by the Secretary and approved.

The applications for membership in the Association of the following physicians were read and referred to the Standing Committee: Drs. Shavarsh Markarian, Nathan Sonkin, and Robert Jerome DuWors.

Dr. Mara reported that over 50 per cent of the members of the Association had enrolled in the Loyalty Group Professional Disability Plan. An extended period of 18 days was granted, during which time those members of the Association who desired could enroll without submitting to physical examination.

Dr. Mara introduced the speaker of the evening, Dr. Francesco Ronchese, Dermatologist-in-Chief of the Rhode Island Hospital, who spoke at length on "Occupational Marks," illustrating his remarks with a series of excellent lantern slides.

The meeting adjourned at 10:30 p. m. A collation was served.

Respectively submitted,

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*Vital Statistics—Special Reports Vol. 25, No. 12, National Office of Vital Statistics, Washington, D. C. (Oct. 15) 1946, p. 206.

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E M I C PROGRAM INFORMATION

TO: State Health Officers

FROM: Edwin F. Daily, M.D., Director, Division of Health Services

SUBJECT: Action by the Congress on the Emergency Maternity and Infant Care Program

On May 7, 1947, I directed a memorandum to you on the expected action by the Congress on the EMIC program and pointed out the action taken by the House of Representatives. Now the Senate has taken similar action on the EMIC program. Therefore, for the fiscal years 1948 and 1949, Fund E may continue to be used for—

1. The completion of all maternity and infant care for wives or infants for whom initial care was authorized prior to June 30, 1947, at the rates established in the official State plan.
2. Maternity care authorized after June 30, 1947, if the mother was eligible under the program as of June 30, 1947, even though she may apply for care subsequent to that date.
3. Infant care authorized after June 30, 1947, if the *mother or infant* was eligible for care or received care under the program as of June 30, 1947. For example, if the wife of an enlisted man in the eligible pay grades became pregnant before June 30, 1947, she would be eligible to apply for and receive services under the EMIC program until 6 weeks postpartum, and her infant would be eligible for service provided under the program until 1 year of age.
4. Costs of administering the EMIC program.

Information concerning these changes in the program should be made known through all possible channels of publicity to reach as many of the families of enlisted men as possible, to all physicians, hospitals, and others participating or interested in the program.

Requests for Fund E, reports of expenditures, etc., should be continued as in the past until all cases are completed.

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BOOK REVIEWS

REHABILITATION THROUGH BETTER NUTRITION.

By Tom. D. Spies, M.D., Philadelphia: W. B. Saunders Company.

Many of the results of Dr. Spies' study of nutritional deficiencies in the Nutrition Clinic of Hillman Hospital in Birmingham, Ala., and the conclusions based on these results are contained in this 94 page monograph. The report covers more than a ten year period of time, during which over 10,000 patients were examined. For the most part, only essential data is given and many of the pages are covered by one or more of the 50 figures. Some of these figures are color or plain photographs illustrating deficiency diseases, while others are tabular or graphic presentations of the compiled statistics. The excellent descriptions of the more common nutritional deficiency diseases with illustrations and the statement of the principles of treating these deficiencies will attract the practicing physician. The monograph will not serve as a handbook of dietary therapy. Statistics dealing with the incidence of nutritional disease and dietary inadequacies will primarily interest workers in the field of Public Health, however, only the minimal statistical information is included. There is disparity between the title and the bulk of the subject matter of this monograph. The title is misleading if one should look to the monograph for help and aid in the long range management of nutritional diseases or expect to find a detailed report of the rehabilitation achieved at the Hillman Hospital. Short range treatment of deficiency diseases is better covered than the long range, and then primarily discussed in principle. Specific treatment for specific deficiencies is illustrated by case histories. Despite the shortcomings of the monograph, namely the misleading title and lack of balance in the presentation of material, the book will be profitably read by the medical profession because the therapeutic principles and clinical opinions of Dr. Spies are sound, forthright, and above all, authoritative.

ROBERT V. LEWIS, M.D.

GYNECOLOGICAL AND OBSTETRICAL PATHOLOGY. By Emil Novak, A.B., M.D., D.Sc. (Hon. Dublin) F.A.C.S. Second Edition with 542 Illustrations, 15 in Color, 545 pages. W. B. Saunders Company, Philadelphia and London, 1947. $7.50.

This recent edition of Dr. Novak's excellent book is a thorough revision and brings the knowledge of obstetrical and gynecological pathology up-to-date. The addition of over one hundred illustrations, fifteen in color, further increases its value. The reference lists now include major contributions through 1946.

It is not, and it is not intended to be, an encyclopedic volume. Its concise and logical form, succinct presentation and complex index make it a ready reference manual to the more frequently encountered pathological conditions. The first edition has gained the stature of a standard text, and this recent revision is a welcome continuation of an authoritative and scientific work.

WILLIAM A. REID, M.D.

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Members of the Society are urged to check carefully on offers sent through the mail offering invitations to participate in an offer of a strictly non-cancellable policy providing lifetime benefits. Several inquiries have come to the executive office from members in the past month regarding such offers.

Two of the companies making the offer are *NOT* licensed in Rhode Island. Hence they resort to appeals by mail. The purchaser of such a policy runs the risk of having to travel to the home office of the company, or even engaging legal counsel to press a claim for benefits. And none of the contracts are as strictly non-cancellable as they are represented to be.

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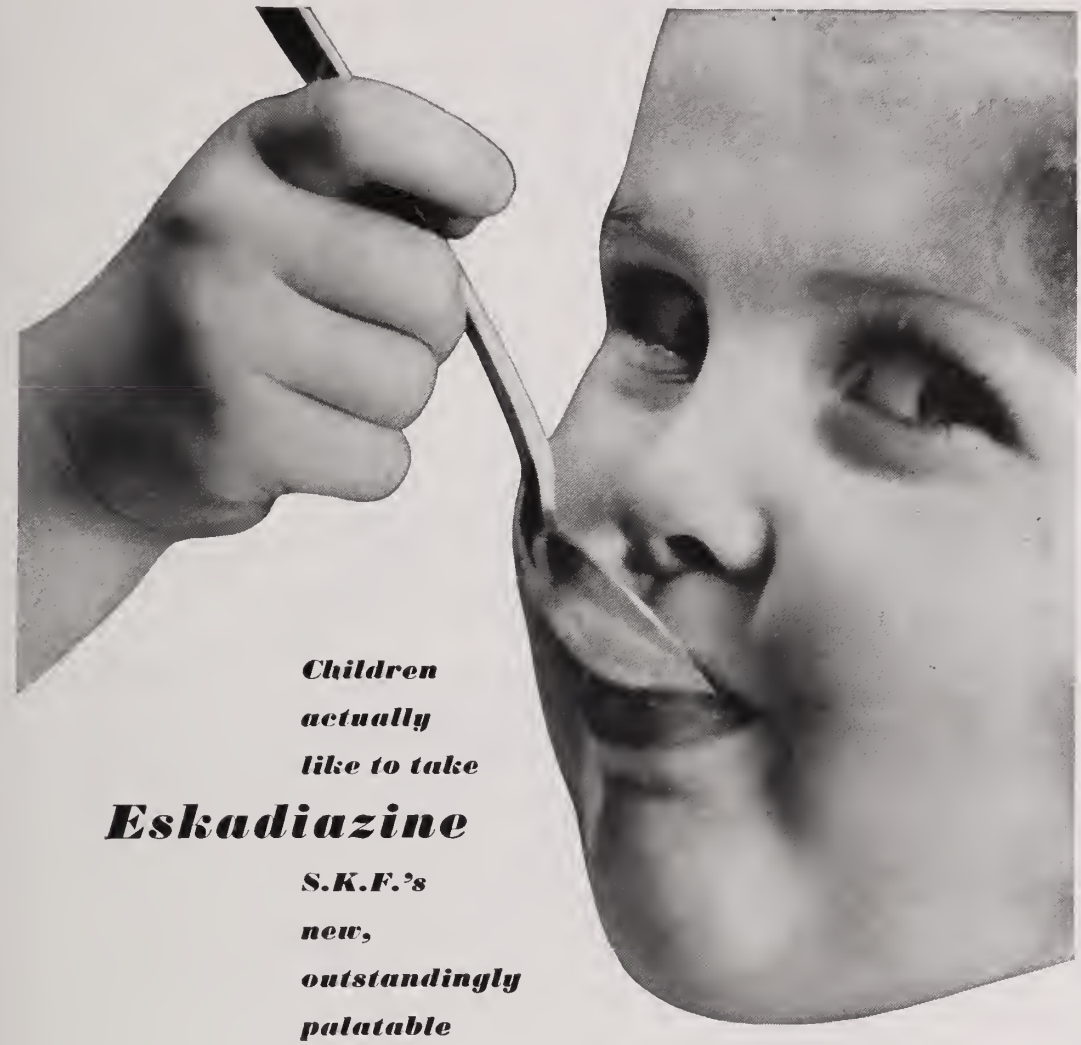
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*Flippin, H. F., et al.: Am. J. M. Sc. 210:141-147, 1945.

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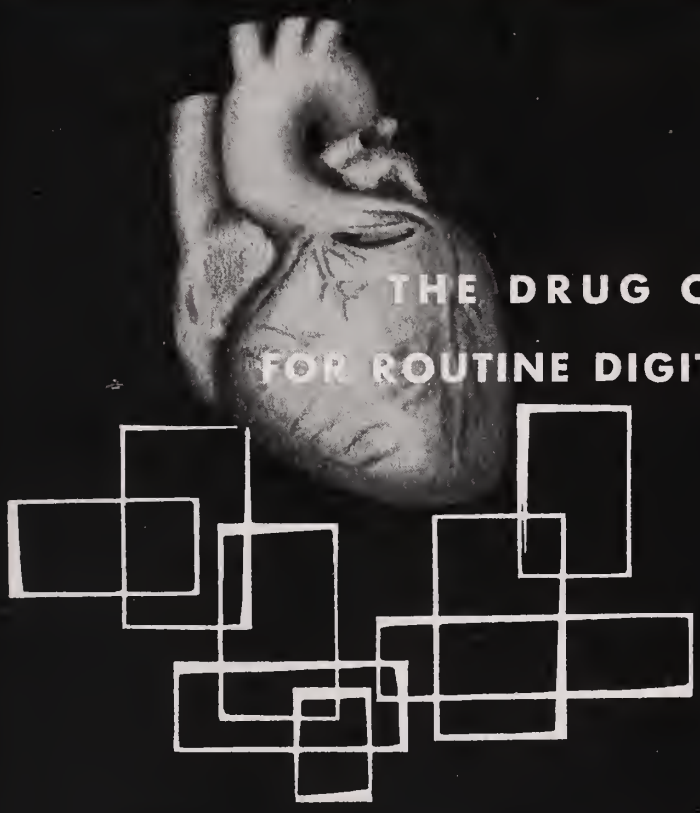
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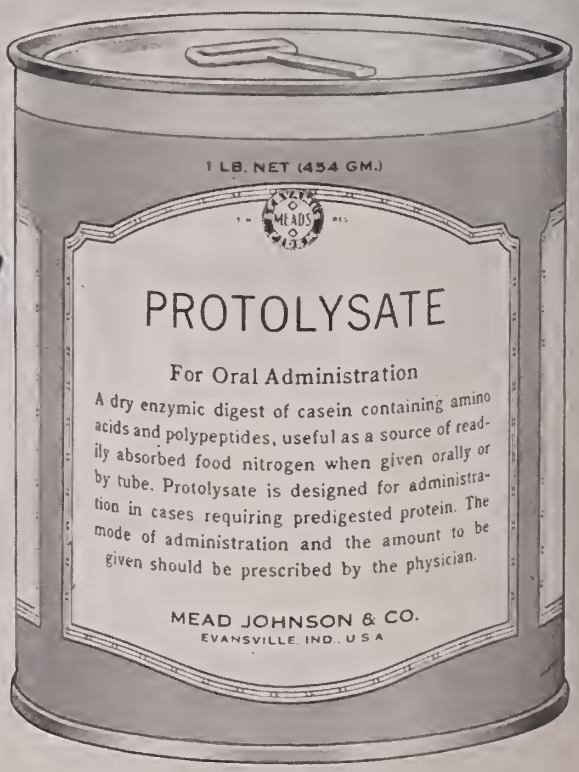
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Volume XXX, No. 7

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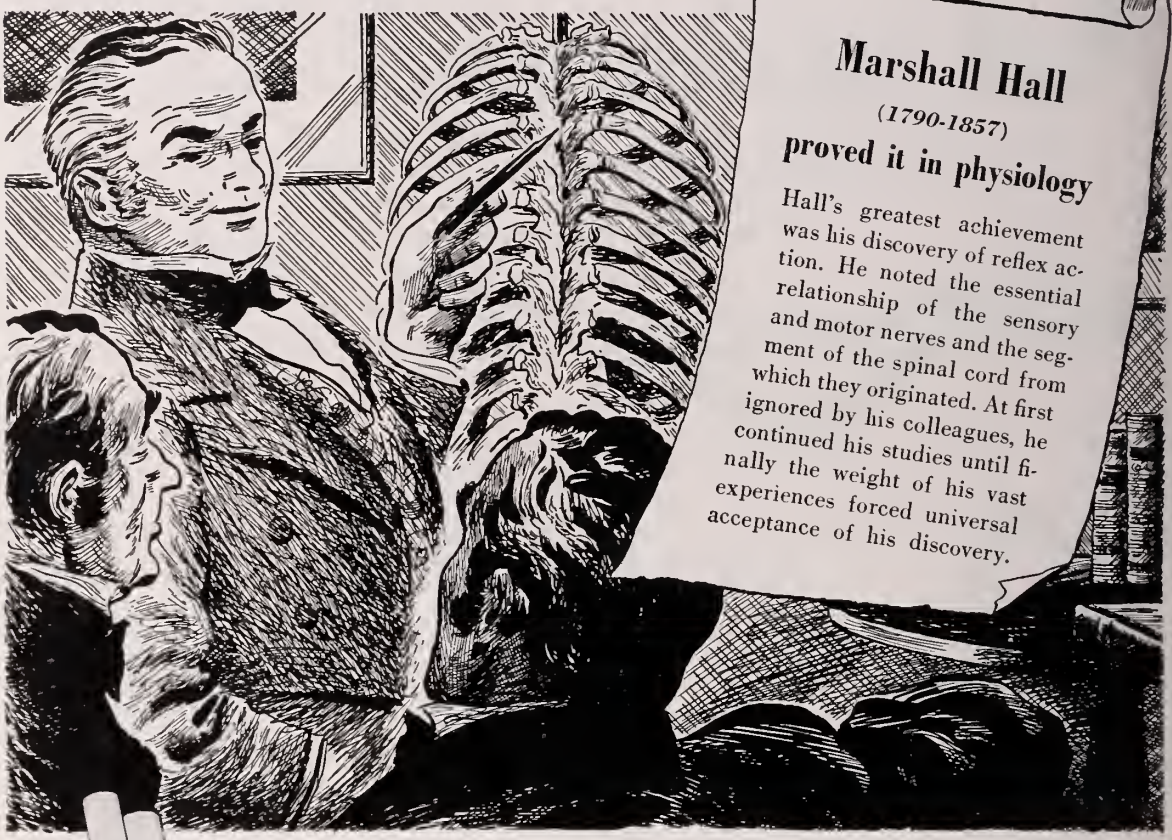
Clinical Entity	Patients	Satisfactory	Questionable	No Benefit	% Showing Improvement
URTICARIA	766	692	16	58	90.3
VASOMOTOR RHINITIS	349	268	2	79	76.7
ECZEMA	128	79	7	42	61.7
HAY FEVER	425	350	36	39	82.4
ASTHMA	435	275	7	153	63.2
MIGRAINE	73	48	1	24	65.7
ANGIONEUROTIC EDEMA	54	46	1	7	85.2
ATOPIC DERMATITIS	66	42	1	23	63.6
PRURITUS	24	18		6	75.0
ERYTHEMA MULTIFORME	28	22		6	78.6
DERMOGRAPHIA	20	15		5	75.0
FOOD ALLERGY	37	32		5	86.5
CONTACT DERMATITIS	63	49		14	77.7
PHYSICAL ALLERGY	11	7		4	63.6
REACTIONS—ANTIBIOTIC	84	81	1	2	96.4
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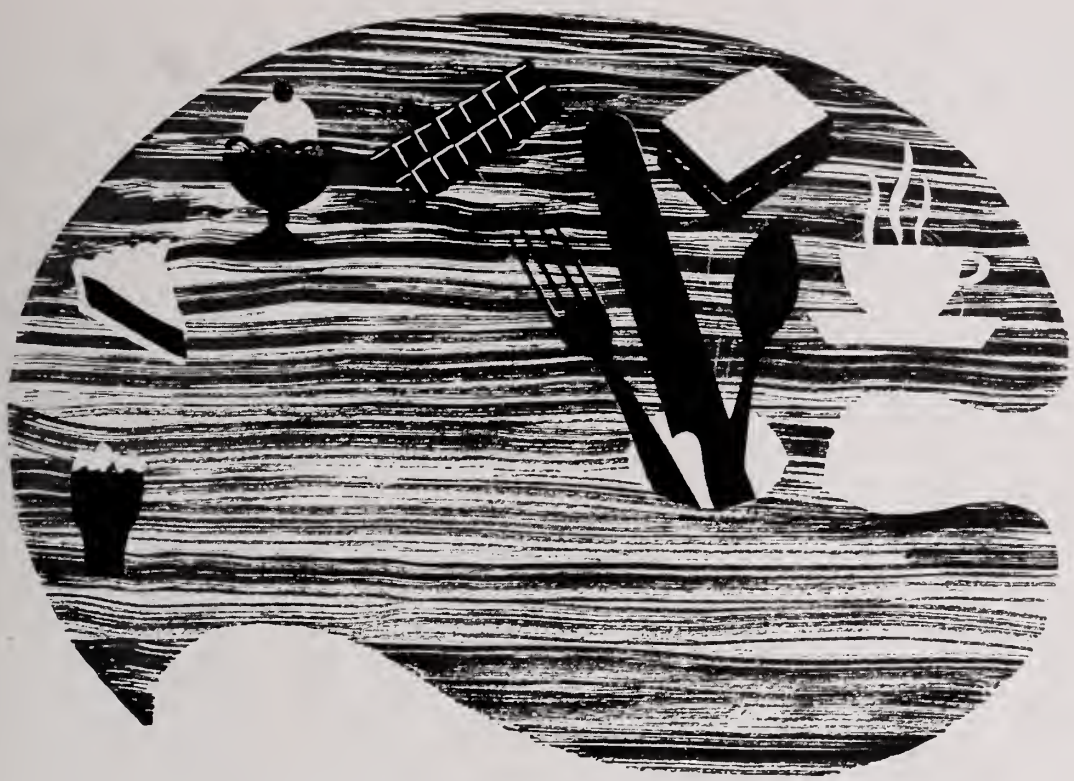


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1. J. South Carolina M. Assn. 52:186 (July) 1946.

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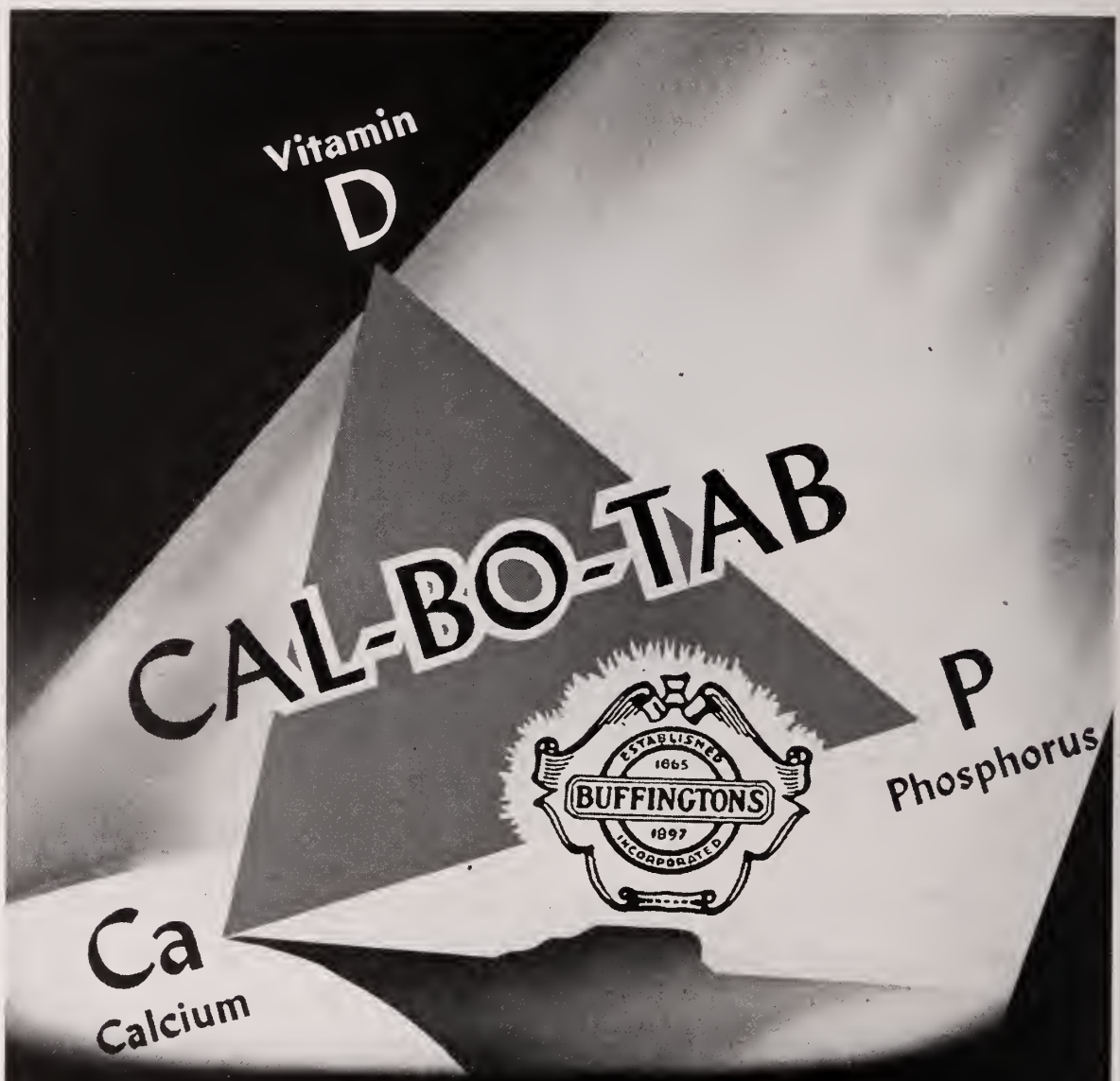
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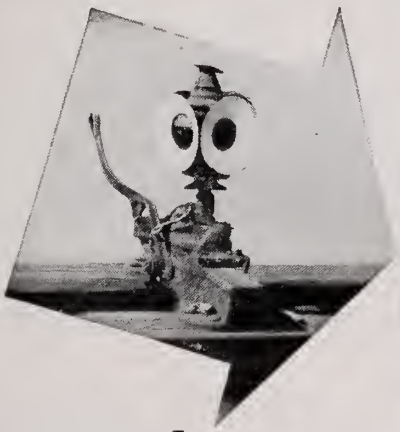
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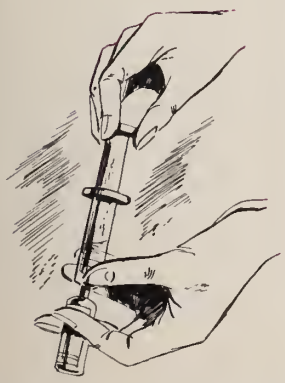
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXX JULY, 1947 No. 7

USE OF ESTROGENS AND PROGESTERONE*

ELMER L. SEVRINGHAUS, M.D.

The Author. *Elmer L. Sevringhaus, M.D., of Montclair, New Jersey. Director of Clinical Research, Hoffman-LaRoche, Inc., Consultant in Endocrinology and Nutrition; formerly Professor of Medicine, University of Wisconsin; author of "Endocrine Therapy in General Practice."*

THE HORMONES which have essential uses (especially appropriate) in the female include the estrogens and the progestogens. Of the first there are several, which need to be identified. The most potent per milligram is estradiol, which may be administered in this form, or for more prolonged action in the form of a benzoate or propionate ester, which is slowly hydrolyzed after injection. Because of cost estradiol is often replaced by one of the estrogens which occurs as a urinary excretion product, either estrone or the less potent estriol. A widely used preparation which is called by the Council on Pharmacy and Chemistry "Estrogenic Substances" contains all three of these substances but estrone is predominant. This may be prepared in various stages of purity. Being a mixture, it cannot be standardized in weight terms, but is measured in biological units, compared with international standard estrone. One unique estrogen is ethinyl estradiol, a synthetic derivative of estradiol which is efficiently absorbed when given orally.

The completely synthetic estrogens include the best known diethylstilbestrol, often called stilbestrol, and modified forms such as methyl ethyl stilbestrol and hexestrol which have slightly different characteristics of absorption and activity. Two other synthetics are benzestrol of somewhat lower potency, and the more recently tried dienestrol with very high potency. The general advantage of these synthetic drugs is their small loss when they are given orally instead of parenterally. The disadvantage is the tendency to cause nausea in a significant proportion of women who use them. In spite of the lower cost of the synthetics generally, they are certainly not replacing the natural estrogens.

The types of preparation available are almost as varied as the number of estrogens. The low solubility of estrogens and their esters in water, and the fact that an oil solution placed intramuscularly serves as a reservoir for continued absorption over a period of several days, while the estrogens dissolve out of the oil into the aqueous tissue fluids, has resulted in a great vogue of injection oil solutions. The disadvantages of these injections are that the oils tend to remain where they have been injected, that frequently foreign body reactions occur about such masses of oil, that there are occasional allergic reactions to the oil solvents, and that the absorption from such a depot is not uniform throughout the week or ten days usually allowed to occur between injections.

A more recently introduced technique for obtaining sustained activity of the individual doses is the placing of pellets of pure hormones in loose subcutaneous tissue spaces. Disadvantages include difficulty in establishing the appropriate dose, foreign body reactions, and difficulties in assuring and maintaining sterility of the solid pellets during the technical procedures of introducing the doses. It seems probable that this method will be interesting but not a serious competitor for wide use.

Within the past few years a number of experiments have shown that it is possible to administer the estrogens as a suspension of microscopic crystals in water, sometimes stabilized by addition of substances which delay settling of the small crys-

continued on next page

* Presented at the 136th Annual Meeting of the Rhode Island Medical Society, at Providence, May 14, 1947.

tals. This method seems to achieve the advantages of the oil solutions without the handicaps mentioned. Wider future development is predicted.

Any of the estrogens may be administered orally with typical effect. There is a large loss of potency which has been explained on the basis of chemical changes of some of the estrogens by the liver and excretion of these compounds in the bile. Certain of the metabolic products retain a portion of their estrogenic activity, as for example estrone made from estradiol. One may have to use as much as five times the dose orally that he would give parenterally. If the oral preparations can be made less costly by using less highly purified materials and omitting sterilization for ampul preparation, the cost of the larger amount of hormone may not be a significant handicap. Oral therapy is widely used. Its disadvantage, aside from the dose, is that self-medication is more apt to occur with oral preparations. On the other hand the use of one or more doses daily tends to provide a more uniform level of estrogenic activity than does injection at intervals of a week.

Estrogens can be administered percutaneously, either as alcoholic solutions or in cosmetic creams. This latter route is at present largely out of professional control, with dosage indeterminate. Estrogens so administered may give general or systemic results, but this route is in use chiefly by women who are seeking to avoid or remove the senile changes about the face. One recent paper gives objective evidence that some benefits can be secured. Medical supervision of this type of therapy is a matter of real importance. There is a further possibility for local application in the relieving of senile changes about the pudendal area in many women who suffer from pruritis or advancing changes in the vulva and vagina.

Estrogens were administered by vaginal pessaries or suppositories in the early days of estrogenic therapy for the menopause syndrome This route is inefficient in terms of the dose absorbed, and undesirable from an esthetic point of view. But it is still helpful when there is any reason to secure the rapid maturing of an adult type of vaginal mucosa in a pre-adolescent girl. This was formerly much used in treating pre-adolescent gonorrhea but has become less important with the introduction of effective antibiotics.

The progestogenic hormone picture is far less complicated. One hormone occurs naturally, progesterone. The known metabolic end-product, pregnandiol, is not biologically active. This occurs in the urine, representing less than half the progesterone produced or administered. Since oral administration of progesterone is ineffective, there has been developed a modified form which is made synthetically, called pregneninolone. The dose of this preparation by mouth must be some ten or more times that of the parenterally administered progesterone to obtain a similar effect. Progesterone is administered in oil solution only. In contact with water it is subject to gradual oxidation.

Anterior Pituitary and Ovary Relationship

For an understanding of the physiology of ovarion action, the interactions of the anterior pituitary and ovaries must be included. The term "gonadotrophic hormone" is applied to substances which stimulate the gonads, either ovary or testis. At present there are thought to be at least three such hormones produced by the anterior pituitary. These cause the Graafian follicles to grow and develop, usually one at a time. At the peak of follicle development, the matured ovum is extruded from the ruptured follicle. Following this ovulation the pituitary hormones bring about a change in the follicle cells which has led to the name "corpus luteum." After a period of about one week of activity, the corpus luteum begins to atrophy, eventually disappearing. Neither follicle development, maturation of ovum, ovulation, nor formation and function of the corpus luteum can occur without the gonadotrophic hormones.

A still more puzzling situation is produced by the fact that the follicle produces estrogenic hormone and the corpus luteum secretes progesterone. These hormones have their best known effects upon the uterus, Fallopian tubes, vaginal mucosa, and breasts. But estrogenic hormones and progesterone exert a series of effects upon the anterior pituitary gland. Although the details of this reflex action are still imperfectly understood, it is certain that the dependably regular recurrence of cycles of ovarian functions as described are brought about by the combined effects of pituitary upon ovaries and of ovarian hormones upon the anterior pituitary. Possible uses of the ovarian hormones in attempts to alter pituitary function will be mentioned later.

Indications for Use of These Hormones

The most obvious use of estrogenic material is for replacement in the menopause syndrome. The only need is to give relief from the numerous symptoms, but when these do not occur or are very mild, therapy is not required. The use of estrogens should be started with a large enough dose to assure significant relief within the first week. The doses may be adjusted upward by rapid stages to secure complete comfort in a few days in most cases. When this point has been reached it is wise to reduce more slowly the amount of estrogen employed until recurrence of some of the typical complaints indicates the need for return to a higher level. Once this satisfactory minimum dose has been reached, there is only one way to find when it is no longer required: reduce the dose again until symptoms recur. Eventually it always becomes possible to eliminate estrogen entirely without re-

turn of the menopause syndrome. The duration of treatment may be from a few weeks to several years. Certainly there is excellent reason to assure women that such a program of therapy does not prolong the readjustment, nor make it necessary to undergo such a period after withdrawal of the treatment. The readjustment is made essentially asymptomatic by therapy if the program is skillfully handled.

There are frequently women who have the typical complaints suggesting the climacteric syndrome, but who continue to have menstrual function, often for many years. Although sometimes this may be referable to disturbances in the central and vegetative nervous systems, it is common to find other evidences of hypofunction of the ovaries. There may be menstrual irregularities, low fertility, or poor feminine development to indicate possible estrogen deficiency. Estrogenic therapy may be as helpful as in the truly menopausal women, but the syndrome is commonly of variable intensity, and use of a fixed dose level of administered estrogen gives variable comfort to the patients. Such women need a greater amount of clinical experimentation with doses to secure the best results. It is rather probable that such conditions can be managed with greater ease if combined use of estrogen and progesterone are tried. If one can estimate the timing of the menstrual cycles well enough in advance, he would add to the routine estrogen a significant dose of progesterone through the third week, and either reduce the estrogen sharply or withdraw it entirely during the fourth week, resuming estrogen again as soon as the flow is well under way.

When adolescent development is significantly delayed or when a woman of mature years desires treatment because of inadequately developed breasts or internal genitalia, the problem is essentially similar to that presented by infrequent menstruation or by amenorrhea which is not caused by pregnancy, the menopause, or obvious systemic diseases. The choice needs to be made between stimulation of the ovaries by means of gonadotrophic hormones from the pituitary or pregnant mare's serum, or substitution with the products of the ovaries, estrogen and progesterone. These latter may be expected to give more prompt responses, as well as to operate in certain cases where the ovaries are refractory for unknown causes. Until this refractory state has been found by trial it seems preferable to employ the gonadotrophic hormones, since at times these have led to ovulation and fertility. Substitution with ovarian hormones will not stimulate the ovaries, unless by some possible reflex action, via the pituitary, ovarian function may be improved. This latter possibility is too uncertain for any other than frankly experimental therapy. If substitution therapy with ovarian materials is to be undertaken, it is urged that regular cycles of estrogen for at least three weeks be accompanied during the third week by progesterone. The fourth week may be marked by complete withdrawal of hormone treatment, or by continued use of a minimum dose of estrogen if there are symptoms which seem to be kept in abeyance thereby.

In order to induce ovulation a number of procedures have been tried but none can be considered dependable. Intravenous use of gonadotrophic hormones has been reported but with the present impure hormones this is not advisable. Cycles of use of such hormones hypodermically during the first two weeks of the cycle, when that timing can be recognized, have led to ovulation proven in a few instances by pregnancies. There is some reason to think that the normal mechanism which initiates ovulation is a sharp rise in the amount of estrogen released from the ovaries. This affects the anterior pituitary, leading to sudden release of the trophic hormones which in turn affect the mature graafian follicle, and cause ovulation, which is followed by formation of a corpus luteum. Therefore attempts have been made to induce ovulation in women who have frequent anovulatory cycles by giving a large single dose of estrogen at about the fourteenth day of a cycle. This is without known risk. The efficacy can be told by improvement in fertility, or by comparative endometrial biopsies at the end of the third week with and without therapy, or by determinations of the pregnandiol excretion over the several days following the therapy as compared with a similar time in an untreated cycle. These criteria indicate the difficulties in proving the efficiency of this method of therapy and shows why reports on large series are lacking.

Several uses of estrogen have become associated empirically with dermatologic practice. There is a chronic cystic type of acne seen in mature women as well as occasionally in adolescent girls, which appears to respond better to local application if these patients receive small doses of estrogen over long periods of time. If the doses of estrogen are too large the menstrual cycles may be made irregular. Small doses do not disturb the cycles. It is extremely difficult to secure more than clinical impressions on this matter of results in acne, but experience on this point is widespread.

There are changes in the skin associated with the climateric which include a thinning of the epidermis, decrease in the subcutaneous connective tissues, and decreased vascularity. These changes may be of only cosmetic import on the face and neck but may also be the cause of great discomfort and susceptibility to trauma and infection about the genitalia. Application of estrogen locally has been known to help the pudendal lesions, which respond also to large doses given systemically for the treat-

continued on next page

ment of climateric symptoms. In the past few years the use of estrogens in cosmetic preparations has become common but only recently has there appeared any exact study of the skin and adjacent tissues to afford objective data that such therapy accomplishes more than similar creams without the hormones. It now appears that the use of the hormone on the skin is followed not only by absorption, as has been known for a number of years, but that the effects are marked locally with improvement in the thickness of a senile thin skin, and improvement in the atrophied connective tissues beneath the epidermis. The quantitative aspects, doses required, permanence of results, and many other details remain to be determined.

One very natural question which is raised by this technique is the possibility of inducing malignant disease by use of estrogens daily on the skin. The fear of initiating malignant growths by any clinical use of estrogens is obviously decreasing in the last few years. Those men who are engaged in experimental study of cancer tend to the opinion that estrogens do not furnish the stimulus which initiates malignant growth, but that given such an initiating factor, whatever it may be, estrogenic hormones are growth stimulants for genital tissues, breasts, and possibly the skin. Whether every possible source of estrogen should be eradicated from women with certain types of cancer remains under debate. If the decision is made to remove the ovaries for this reason, then there is equally good reason to withhold all estrogens including cosmetics from the same patients. It is too early to contemplate the hormone-containing cosmetics with entire complacency.

The use of progesterone has far fewer indications than is the case with estrogens. In addition to the situations described above, which might be generally described as inadequate ovarian cycles, the two other major indications for use of the corpus luteum hormone are in repeated abortion and certain toxemias of pregnancy. The latter have been under study by Priscilla White and the Smiths, with much attention to pregnant diabetic women. Here there has been a remarkable improvement in maternal morbidity and infant survival following the use of large doses of estrogen and what seem like impossibly great doses of progesterone. Such treatment needs to be continued well past the beginning of the second trimester. The final details are still to be determined. The most recent papers of these authors need to be consulted for directions. The large doses of progesterone advised will soon be available for more patients since commercial preparations of progesterone are now being reduced in cost, together with introduction of higher concentrations of the hormone in the oil vehicles for injection. It seems probable that better results will be secured if more generous doses of progesterone are employed in treating women who have suffered abortion repeatedly in the first trimester. This should be started as soon as the probable ovulation has occurred, even before the first missed menstrual period, and be continued to the early part of the second trimester, possibly longer. Such advice poses a difficult question: adequately large doses of progesterone continued from the time of ovulation will postpone menstruation for long periods and might therefore lead to a period of treating a woman as though she were pregnant whereas she has not conceived. The risk of such expensive therapy being ultimately futile is to be balanced against the urgency of stabilizing the much desired pregnancy.

One other use for progesterone which is not widely explored is in the treatment of women whose breasts become painful, tender, and marked by a temporary engorgement of glandular structures. The etiology of this condition is by no means entirely understood, but the condition seems at times to result from persistent use of large doses of estrogen or to be aggravated by such therapy. Use of brief periods of progesterone treatment, such as three to seven days, may lead to prompt relief from the discomfort, and loss of the turgidity in the breasts judged by palpation. Such cycles of treatment may be repeated when indicated. In some women relief is obtained with a total dosage of a few milligrams.

The Cause of Menstruation

The mechanism which leads to menstrual flow continues an object of much study. The usual explanation has been that of estrogen withdrawal or progesterone withdrawal. It is known that flows usually follow either of the following two procedures: (1) if the endometrium is caused to develop by an adequate supply of estrogen, which is then greatly reduced or entirely withdrawn; (2) if estrogenic stimulation is followed by an adequate supply of progesterone, which is in turn greatly reduced or withdrawn. In the latter case flow follows even though the estrogen level is unaltered.

Certain difficulties with the explanation just outlined have compelled several investigators to search for still further factors. Recent suggestions made are as follows. A globulin derived from certain alterations in the endometrium (G. V. Smith and O. W. Smith) acts as a vasoconstricting agent upon the sphincteric muscles in the walls of the smallest arterioles in the endometrium. The result includes a shift of circulation from capillaries to the arterio-venous anastomoses or venous lakes in the endometrium. This induces a relative anoxia of the tissues, which leads in turn to foci of necrosis, and shedding of the necrotic tissue with some blood loss follows. (Okkels; Markee). It may be men-

continued on page 516

LOBOTOMY*

HANNIBAL HAMLIN, M.D.

The Author. *Hannibal Hamlin, M.D., of Providence, R. I. Consulting Neuro-Surgeon, Butler Hospital, Emma Pendleton Bradley Home, Chelsea Naval Hospital, and Boston State Hospital.*

PREFRONTAL LOBOTOMY or leucotomy is a neurosurgical procedure which has proven itself to be of benefit to a proportion of individuals among those selected for this form of treatment in certain types of neuropsychiatric disorder or disease of the personality. One of the chief aims of psychotherapy, whatever its method, is to change people. This goal is not readily attainable because the human personality is rooted in a genetic pattern that parallels the fixed character of somatic individuality. The individual personality is conditioned and modified by environmental experience that furnishes the data through which the psychiatrist interprets the patient's difficulty and decides what means he will use to effect possible change. He may choose to work indirectly through the environmental experience of the subject; he may choose drugs or talk, or some kind of shock treatment. Alteration in the subject's reaction to his disease, which brings about sustained improvement in his behavior and social adjustment, is the ultimate goal. Lobotomy appears to cause a more permanent change in the deranged personality than any other form of treatment. Whether or not the outcome is for the better depends mainly upon the selective judgment of the neuropsychiatrist.

Elective incision of the prefrontal portion of the brain is the application to psychiatry of a surgical method derived from observations extending over 50 years in several related fields: The results of injuries to the frontal lobes and resection for tumor, cyst, or abscess; the study of animal behavior following extirpation experiments on the brain affecting the prefrontal areas; from neuroanatomical research on the cortex and its connections, and especially the phylogenetic and developmental relationships which have been correlated with psychological function.

* Presented at the 136th Annual Meeting of the Rhode Island Medical Society, at Providence, May 15, 1947.

"Change of personality" is a familiar notation on the records of frontal lobe syndromes and represents the external manifestation of change, both qualitative and quantitative, in vegetative, emotional, and inhibitory impulses on the projection system of the frontal cortex. The interneuronal connections of the frontal lobe, being of greater number and extent than any other of the conventional cortical divisions, reflects disease more often in the personality than in neurologic signs of precise localization. Symptoms related to areas anterior to motor and premotor are not displayed in mode of specific function but with reference to total behavior: Attention, recall, emotion, perception, posture — these are general attitudes, but they mirror the individual. They are not easily interpreted and catalogued in the handbook of differential diagnosis.

Personality change in tumor or degenerative process of the frontal lobe may be so insidious as to escape detection until far advances. Traumatic lesions furnish more dramatic clinical evidence of the physiological role of the prefrontal areas. The case of Phineas Gage, who had an iron bar blown upward through his anterior fossa in 1848, is impressed upon medical students as an encouraging example of how they can probably get along all right minus most of their brains. You will recall how Phineas Gage, following his injury, changed from a taciturn and methodical construction foreman to a character described as "fitful, irreverent, indulging at times in the grossest profanity (which was not previously his custom), manifesting but little deference to his fellows, impatient of restraint or advice when it conflicts with his desires, at times pertinaciously obstinate yet capricious and vacillating, devising many plans for future operations which are no sooner arranged than they are abandoned in turn for others appearing more feasible." Or take a case from my own war experience: A modest, serious-minded Marine corporal, who recovered from a gunshot wound through the temples, complicated by meningitis, to became a cheerful extrovert who discusses his blindness with carefree levity. There are many similar instances of personality change in individuals who have been accidentally lobotomized or surgically lobectomized

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for a frontal lesion. They have taught us much about the potentialities of the forebrain; and principally that it must be treated with great respect.

Dr. John Fulton, Professor of Physiology at Yale, probably could be called the modern stepfather of psychosurgery: and he would undoubtedly regard his many children as illegitimate at the present time. It was his outstanding experimental work (with Dr. Jacobsen and others) on frontal lobe physiology in primates that gave first impetus to lobotomy. Their presentation at the London International Neurological Congress in 1935 included observations of improved temperament and tractability in chimpanzees subjected to cortical excision primarily for the purpose of studying motor behavior. Egas Moniz, the Portuguese neurologist, was thereby prompted to try prefrontal incision on human psychotics. He had long considered the possibility of operating on the brain for the relief of mental symptoms, a feat which Burckhardt had attempted 50 years previously, also on the basis of earlier animal experimentation by Goltz. Moniz in Europe, who was, by the way, almost killed in 1939 by the homicidal attack of a deluded patient, and Freeman and Watts in America deserve pioneer credit for the rational development of lobotomy during the past decade and for its increasing acceptance by psychiatry. Major guidance, however, has been provided by neurophysiology. Fulton and Jacobsen in 1934, commenting about a chimpanzee that before operation threw temper tantrums when mistakes were made (having to do with food reward) in delayed reaction or other tests of recent memory performance, stated that removal of frontal cortical areas appeared to reduce the capacity for recall and to increase the importance of immediate sensory cues as determinants of response, possibly thereby preventing the occurrence of experimental neurosis in more complex and abstract situations. The chimp had been trained to utilize a variety of sensory stimuli to solve mechanical problems that would tax many a human brain. Following a specific type of operation on the forebrain and a considerable vacation away from experimental apparatus, the same animal, nevertheless, was able to reproduce its complicated preoperative performance fairly well under similar conditions. Explosive frustration reactions, precipitated before operation by errors precluding food reward, no longer occurred. The inference here clearly parallels the emotional improvement witnessed in the human case of agitated psychosis after lobotomy.

There is evidence to indicate that the mesial-orbital cortex of the frontal lobe (which I shall show you later) plays an important role in the motivation of emotional activity. When fiber tract connections in this region are cut in the ape, the animal exhibits the type of behavior just described; but ablation of this area may produce a condition stimulating sham-rage, or a disturbed state of hypermotility — the so-called pacing reaction in which the animal spends most of its time pacing back and forth in its cage. Experimentation of this type in neurophysiology and psychology will continue to provide invaluable direction to those who recommend and carry out lobotomy in man, not the least of which will be to stay the hand of the enthusiast.

Prefrontal lobotomy has been called (by one of my urological friends) the egg-beater operation and not perhaps without some slight justification. The technique is no more imperfect than our knowledge of frontal lobe function. The procedure is not simply a matter of sticking an instrument in somewhere up forward and stirring it around. We have incomplete but fair information about the neuroanatomical pathways and the related nuclear centers that are affected by lobotomy.

A variable proportion of long and short association bundles, depending on the extent of the incision through the white matter, are divided in the coronal-sphenoidal plane thus diminishing in variable degree the interconnections between area 13 and adjacent areas, the function of which is also poorly understood—thus diminishing their intercommunication literally with the rest of the brain.

The human cerebral cortex, representing the most highly differentiated part of the brain in its evolution, is really 3 lobes instead of 5 — right and left. Five lobes have been handed down by anatomical tradition as a convenient way to divide up the gross surface of the organ; but functionally and in kinship to lower forms there are only 3 on each side which have been designated the outer—ectocortex, middle—mesocortex, and inner—entocortex.

These three lobes maintain a constant relationship with one another and the rest of the nervous system throughout vertebrate morphology. In man the frontal portion of the outer or ectocortex, in contradistinction to the remainder of the entire cerebral mantel, is unique in having by far the greatest number of interconnections with other functional units of the nervous system, irrespective of anatomical arrangement.

Prefrontal 13, 14 and possibly adjacent areas 9, 10 and 11 are greatly influenced by autonomic impulses having to do with vegetative and instinctive motivation, mediated by circuits to the hypothalamus, some directly but mostly indirectly through the thalamus. It is by severing part of the myriad of connections between these most recently developed areas and those of older and less modifiable function (thalamus, hypothalamus, and other cortical areas) that lobotomy theoretically aims to improve the sick personality.

The thalamus and the geniculate bodies, which are an integral part of it, is the principal synaptic surface of sensation. Through its portals pass everything from the most beautiful girls in the world to a glimpse of eternity. External and internal stimuli of all kinds are registered here as on a radar screen where they are processed and redistributed for shaping conscious activity or for storage in the unconscious. The thalamus and cortex act like an electrical feed-back system; but the ratio of output from thalamus to what is returned from cortex is about 8:1—a preponderance that overshadows linkage with basal ganglia, midbrain tegmental nuclei and other centers. Lobotomy, therefore, divides many more thalamofrontal fibers than fibers flowing in the opposite direction.

We can name bundles of fibers that are divided or partially divided by the operation, but they represent unfamiliar gross structures that have little physiological meaning:

1—superior longitudinal fasciculus—short relay association tract

2—cingulate bundle—short relay association tract

3—uncinate and medial orbital bundles—long relay association tracts

4—possibly some fibers of inferior longitudinal fasciculus and maybe others—? subcallosal

5—these long and short relay association tracts link up the three basic divisions of the cortex previously mentioned — outer ectocortex, middle mesocortex (cingulum), and inner entocortex (olfactory)

6—interconnecting direct relays between thalamus, hypothalamus, and prefrontal cortex, many of which are hypothetical

Degeneration, chiefly thalamofugal and in the dorsomedial nucleus of the thalamus, has been recorded from post-lobotomy cases of several years' standing who have come to autopsy.

Hypothalamus is also included in this complex hookup, but less is known about this vital structure than is known about the atomic bomb. Perhaps we can borrow from the physicists and say that the purpose of lobotomy from the neurophysiological standpoint is to diminish the impact or exchange of energy in the trinitarian system of sensory perception and projection—thalamus, hypothalamus, and prefrontal cortex (Many other cortical areas are included secondarily in this complicated mechanism—paracentral and parietal sensory cortex, occiptal visual, auditory, etc.)

Now, what does all this mean in common sense medical language? It means that at least 10 per cent, by conservative guess, of persons suffering from mental disorders of many kinds, both in and out of institutional confinement, may be helped by lobotomy. The procedure has been carried out on approximately 0.3 per cent of an estimated 650,000 insane population in the U. S. from official figures with variable improvement in approximately half the cases.

There is scarcely an age limit. If the patient is sound enough to withstand any type of major operation, he will survive lobotomy. A large portion of those who have been lobotomized have come from state asylums where diet and physical hygiene are below the average civilian standard. The chief immediate hazards are hemorrhage and infection, which are not peculiar to neurosurgery alone. The mortality should not exceed 1-2 per cent.

Successful lobotomy depends primarily upon successful cooperation between the neuropsychiatrist and the neurosurgeon. One recommends and the other operates. The former also follows the case for a long period afterward, but the neurosurgeon also looks over his colleague's shoulder occasionally. Although it is presuming for me to discuss indications and results from the psychiatric standpoint, I shall try to do so briefly because many of you are probably more interested in this aspect than in what has gone before.

Lobotomy has been done on nearly every type of psychotic disorder. As in shock therapy, selection is based on symptoms rather than on classification of mental disease. I have lobotomized a 13-year-old imbecilic boy because of continuous assaultive and destructive behavior and a 76-year-old female with chronic involutional complaints. The symptomatic improvement was excellent in both. Most encouraging follow-ups are obtained in the affective reaction syndromes: Involutional melancholia and chronic recurrent depressions of variable cause and content. Less encouraging are cases that might be called the psychoneurotic-compulsive-obsessive group, and least improved are the schizophrenics, although brilliant results can be cited among the latter. Schizophrenia, comprising the most heterogenious and malignant aggregate of all, naturally presents the greatest difficulties of selection. The operation has also been used to ameliorate the terrible reaction caused by intractible pain in patients not amenable to anatomical block by incision of the conduction pathways. Prolonged pain gives rise to a type of symptomatic psychosis; lobotomy somehow appears to dampen the overwhelming bombardment of pain on consciousness.

My experience is not unlike that of others who have drawn their material largely from the inmates of state institutions. Patients assigned to me at Boston State Hospital generally were the most aggressive, noisy and assaultive—who required the greatest amount of nursing supervision from a

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OCCUPATIONAL MEDICINE AND ITS RELATIONSHIP TO PRESENT DAY INDUSTRIAL RELATIONS*

C. F. YEAGER, M.D.

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AMERICA has learned one big lesson from the war: that when employe and employer really and truly cooperate in the interests of all-out production, the output of their factories and business cannot only be doubled but in some cases trebled. This is not theory, it is the actual war production record of the greatest industrial country in the world. The record will stand for all time, as proof of what free labor and free management working together can achieve. The good employe-employer relationships which existed during the war was somewhat enhanced by a sense of duty and patriotism on the part of management and labor. In addition there were war-time government restrictions placed on both. In the wake of the war these reasons no longer exist.

The war has conclusively proved the costliness and foolishness of industrial strife, bickering and misunderstanding. The successful business today must concern itself seriously with building sound relationships with their employes and failure to promote better human relations will result in the failure of our system of free enterprise and free labor. The situation is a challenge to the leaders of both management and labor who are jointly responsible for industrial relations. Upon them must fall the task of "selling" the importance of cooperation to both labor and management. Upon them depends, more than upon any other group, the creation of an employe-employer environment which will be a firm foundation for an enlightened labor-management relationship.

An attempt will be made in this paper to show that our present day concept of occupational medicine will help to create and maintain health, security, happiness and good morale in industry. In order to do this it will be necessary to review briefly the history and course which medicine has taken in industry.

* Presented at the Annual Conference, New England Industrial Physicians, at Providence, May 7, 1947.

There are many who believe that the changes and progress made in industrial medical practice during the past twenty years have been largely due to the efforts of those engaged in industrial medical work. This is a common misconception; the facts are that industry itself is largely responsible. However, some credit must be given to a certain minority group of physicians who have contributed much to the progress made in this specialized field of medicine. In order to prove this, one need only to consider some of the fundamental reasons why industry ever became interested in this profession. Although industrial medicine has been recognized for centuries it was not until the State Compensation Laws imposed financial hardships on industries that doctors became a necessity. Industry very soon realized that their operation costs and profits were seriously influenced by loss of manpower resulting from injuries. From a Compensation standpoint, two things had to be done to remain in business. First, to provide adequate treatment to the injured; secondly, (and much more important than the first from a cost standpoint), the reduction and possible prevention of all accidents. This program required assistance from two professions, namely, doctors and engineers. The emphasis, as I will attempt to show you, was always placed on prevention.

The physicians engaged by the industries to treat the injured were usually surgeons. In many instances, however, physicians were engaged with little or no special training in surgery. Most always this physician, if he remained in industry, would sooner or later become a surgeon, whether or not he sought out surgery as a specialty. Many of our middle-aged and older surgeons today have attained their surgical experience and prominence via this route. I am informed that this type of surgical residency is now virtually non-existent. There are perhaps two reasons for this; first, because of the policies set up by the surgical boards; secondly, because of the effectiveness of industry's preventive surgical program. In the average industrial city today with a total population of 100,000, there isn't enough major industrial surgery to keep one man busy.

Proud of their efforts in preventive surgery, industry began to explore more deeply the field of preventive medicine. It was reasonable to presume that a worker with all of his facilities and in good health would not get hurt or lose time from work as readily as those who had physical or mental disabilities. These conclusions lead many industries to inaugurate a pre-employment physical examination program which was essentially a screening process. Applicants who had physical or mental defects were not accepted for employment. Labor, in general, reacted unfavorably to this plan. The war altered this policy. Many of the physically and mentally handicapped who were previously rejected for employment were now satisfactorily placed in industry. Consequently the pre-employment or screening physical examination is now called "the pre-placement physical examination".

Most surgeons were too busy to participate in this new phase of industrial medicine. Industry then turned to the medical profession in general for assistance and the surgeon dropped out of the scene. As the program proved itself valuable the examinations were extended to older employes; this plan served at once to establish a satisfactory relationship between the workers and the medical department. Employes with treatable defects were referred to their personal physicians or to proper agencies for supervision. Occasionally during the examination itself it was possible to do some effective health education work. The findings on examination might have revealed the necessity for a job transfer in the interest of health and safety of fellow workers or of a whole department. A timely job transfer might be the means of delaying total disability in the face of a chronic, slowly progressing illness.

Later the program was made to include partial examinations of employes who became ill while at work, and also employes returning to work following an absence due to illness. A full program also included periodic partial examinations of employes known to be working with toxic materials and the accumulated records were made the subject of constant study and review. The information gained was correlated with the knowledge of production men and hygiene and safety engineers concerning the working environments of the employes.

Today many of our industries and businesses are equipped with elaborate hospitals and staffed by full-time nurses, physicians and clerks. The scope of work in organizations with this type of medical service is outlined briefly as follows:

1. Complete pre-employment and periodic physical examinations on all employes, including: chest x-rays, blood counts, serological tests, urine analyses, electrocardiograms and basil metabolism tests.
2. Treatment of all occupational injuries and diseases. Minor conditions are most always cared for by the existing plant medical staff. Major cases are referred to specialists in the various fields: surgeons, oculists, dermatologists, dentists, orthopedists, psychiatrists, urologists, etc.
3. Plant Sanitation and Hygiene:
   a. water supply
   b. general housekeeping
   c. illumination
   d. air conditioning
   e. noise control
4. Personal Hygiene for Workers:
   a. toilets and washrooms
   b. fatigue control
   c. nutrition — lunch room
   d. housing
   e. recreation
   f. mental hygiene
5. Co-ordination of Industrial and Community Health Service:
   a. communicable disease control
   b. industrial waste control
   c. vital statistics
   d. health and safety codes and regulations
6. Industrial Health Exposures:
   a. abnormalities of air pressure
   b. abnormalities of temperature and humidity
   c. dampness
   d. dusts
   e. infections
   f. radiant energy
   g. poisons
   h. essential toxicology and safe concentration codes
7. Plant Surveys:
   a. identification of exposures
   b. sampling apparatus and analytical methods
   c. control of exposures and maintenance of controls
8. Job and Worker Analyses:
   a. aptitude and psychologic tests
   b. hours of work
   c. shifts — night work
   d. women in industry
   e. environmental factors
   f. peak loads
9. Statistics:
   a. incidence, costs and classification of industrial accidents, occupational diseases and non-occupational disabilities

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10. Workmen's Compensation:
    a. administrative methods, regulations and insurance practices
    b. employment of the physically handicapped
11. Industrial Relations Plans:
    a. insurance plans
    b. sickness and accident benefits
    c. pensions
12. Rehabilitation

Within the past several years, the unions have taken a very active interest in the subject of occupational medicine, health security and welfare. In many instances where adequate medical service was not available in industry they have taken the initiative. It was extremely unfortunate that certain industries and industrial physicians were recently indicted because of this failure to provide adequate occupational hygiene measures for their employes.

Industry through the organization of scientific means for insurance against disease, for its cure and prevention, have an agency within their grasp, perfectly legitimate in its nature, to offset some of the most destructive forms of radicalism, and to protect their workers from the fear that they will be left alone and helpless when they are sick. This is a legitimate motive only insofar as you actually create and provide far better agencies than would otherwise be at hand. Working people are far more subject to charlatanism in medicine, which preys upon superstition and fear, than are other classes. If we can lift the veil of superstition and show the value of scientific prevention and diagnosis, we can leave the cures to take care of themselves. But both prevention and diagnosis are serious and costly studies, and cannot be undertaken lightly or from any purely selfish point of view. The problem, therefore, if it is to be attacked comprehensively, must be by a combined attack, from the humanitarian, the protective and the economic points of view. Each one of these offers a true incentive when it is sincerely used and each suggests its own method of procedure. Taken together, they accumulate a foundation upon which the most effective medical department can be built up and maintained.

The old time industrial physician no longer exists in our most progressive companies today. Employes referred to him many times as "saw-bones" and too often associated him with accidents and a witness against them in compensation cases. Today the employe's health is a major concern of many of our successful companies and the attainment and maintenance of an employe's health is the primary objective of occupational medicine—true Preventive Medicine. In industries where this concept has been put in practice you will invariably find good employe-employer relationships.

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USE OF ESTROGENS AND PROGESTERONE

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tioned that the same globulin, which the Smiths call a "menstrual toxin" is thought by them to be a factor in causing the hypertensive and renal toxemias in pregnancy. It is too early to have any preparations of such globulin for therapeutic trials in inducing menstruation, etc. Further work will be of great interest in our understanding of the numerous types of derangement of the menstrual cycle.

This survey has included only those clinical uses of estrogens and of progesterone which are well known to give dependable results, or which are based on sufficient knowledge of physiology and clinical states to justify reasonable expectation of results. Numerous more speculative and investigative aspects of such therapy must be left for special studies of each detail. The clinician needs to master fundamental physiological relationships between the pituitary which stimulates the ovaries and the ovarian secretions which stimulate the genital tissues, breast, and nervous system. He can then use these hormones with confidence and with success.

VITAMIN ADVERTISING AND THE MEAD JOHNSON POLICY

The present spectacle of vitamin advertising running riot in newspapers and magazines and via radio emphasizes the importance of the physician as a controlling agent in the use of vitamin products.

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RECORDS AND NEUROPSYCHIATRY*

LAURENCE A. SENSEMAN, M.D.

The Author. *Laurence A. Senseman, M.D., of Pawtucket, R. I. Chief, Neuropsychiatry Division, The Memorial Hospital, Pawtucket, R. I.*

THE PURPOSE of my talk today is to bring to you the importance of Psychiatric records and the outstanding differences between the records of a mental hospital and those of a General Hospital. One of the most important points to be stressed is the legal aspects of the work carried on in a mental hospital. As most of the patients are confined in the institution against their will it becomes necessary to have a legal paper of commitment which will protect the institution, thus giving the personnel the privilege of restraining, when necessary, any individual against their will. This paper is probably one of the most important features of the psychiatric record. This particular form varies considerably with individual hospitals and in the various states. The records as kept by a Psychiatric hospital are much more voluminous than those of a general hospital. This, too, is a necessity as psychiatry takes in the total individual and covers every aspect of medicine hence the detailed reports which are attached to the medical record of a psychiatric hospital.

Recently I wrote to three State Hospitals in Rhode Island, Massachusetts, and Connecticut and three private institutions in this vicinity for copies of their individual records as kept by the institution. I received a prompt reply with the material asked for and it was very interesting to see the close resemblance of these records, as to form and detail. It was also an interesting fact to note that the average psychiatric hospital record requires between 20 and 30 records sheets for a comple'e work up. This seems a large number to those who are used to writing up brief histories and physical examinations for the medical or surgical problems in a General Hospital. Psychiatric cases require a detailed personal history of the patient from his birth until the time he enters the hospital covering all phases of his life having any relationship to the development of his psychoses. It also includes a complete family history with emphasis on heriditary factors. It is becoming more important to learn about the birth of the patient, for the knowledge of anoxemia may help us in the understanding of the convulsive disorders, spastic disorders and mental deficiency diseases. It is also important to know about the patient's childhood, his adolescence, his educational background, his occupation, his sexual knowledge and experience, his marital history and also his medical and surgical history. It is very important to know the facts leading up to his commitment and when possible to get a fairly good picture of the personality of the patient before he became sick. Psychiatric examination is important and includes the attitude, behavior, trend of thought, activities, emotional reactions, mental grasps on situations and capacity to remember: all these and others should be included in the psychiatric history.

To present a clear picture of a complete psychiatric case record it should include the following material: a statistical front sheet, copy of the physician's statement or report, an anannesis, abstracts from other hospitals if the patient has had previous hospitalization; physical examination including a complete neurological examination and usually these records are fill-in-sheets for brevity, admission notes with mental status; progress notes, laboratory data, psychologists examinations, reports of consultants, medical, surgical, orthopedic, neuro-surgical etc., x-ray, weight chart, electroencephalography report, behavior chart, accident reports in case of injury during the stay in the hospital; permit blanks for special treatments which would cover lumbar puncture, electric shock therapy or metrazol, malaria, social service and convalescent clinical notes and correspondence, and if the patient should die there should be a copy of the death certificate and autopsy permit and report if this has been secured and finally a clinical summary sheet. This seems like a rather formidable array of records and no doubt discouraging to the new record librarian but let me emphasize again the importance of such psychiatric records from a legal aspect.

Needless to say the records of an institution are the permanent record of that patient during his

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* Presented at the Annual Meeting of the Rhode Island Association of Medical Record Librarians, at Providence, May 14, 1947.

stay in the hospital. They should be written in such a way that five, ten or many years later they can be used as evidence in any court, they can be used for statistical study, they could be used again for reference if the patient is recommitted or if a report is to be sent to another institution. Some times it is very difficult to pick from the record the important features of a person's illness by one who has not written the history of the patient. In the State Hospital records which were received, a summary sheet was a prominent feature of each exhibit. This should include the distinguishing points regarding the patient, the treatment advised and administered, the important laboratory data and any other factors considered important by the physician.

There is another feature involved in mentally sick patients which I would like to point out and which may account for the voluminous records which are sometimes acquired, and that is the fact that patients spend a longer period of time in a mental institution than they do in a general hospital. Therefore, it becomes necessary to re-examine the patient at certain intervals, both from a mental and physical standpoint. Sometimes the patients are in the institution for a period of years and it is very easy to overlook the importance of records in regard to this type of custodial problem. It also brings up the question of progress notes and these may become minimal as time goes on. These progress notes are an important part of the patients record and should include important incidents relating to the patient, yearly physical examinations and mental examinations every six months.

There is a feature of the psychiatric records which I would like to emphasize and that is the confidential nature of the report. Of necessity psychiatrists must ask personal and often times embarrassing questions and the answers recorded. These are not to be used by anyone other than for purposes intended. I find it difficult sometimes to even write down some of the important statements received from the patients because of their very private implication. This entirely confidential material should be kept in strict confidence by the record librarian, the nurses, and by the physicians in charge and if used the name should not be attached to the material in question.

Most doctors have their own way of taking a history and recording the facts which are received. In a psychiatric institution it is sometimes necessary to talk with the patient quite at length without letting them know that you are taking a history on them. This may take a period of days or weeks and an accumulation of data is acquired through these frequent contacts with the patient and it frequently takes considerable time to get to the real core of the problem and the more casual, friendly attitude, the more likely one is to get the information desired. May I suggest here that the most important contact with the individual patient is during the first few visits, and during this time the patient is gaining confidence in the physician or psychiatric social worker and the data secured at this time may include important facts regarding the illness and should be recorded at the earliest possible moment, as it is very easy to forget what the patient has told you after a short period of time. If the histories are to be accurate too much time should not elapse between the contacts with the patient and getting the information in writing.

To the beginner, psychiatric history taking is a formidable task. It is important that the psychiatrist not become more interested in record keeping than in taking care of the patient. There is a tendency in that direction if one is not very careful. The records are to be used to the advantage of the patient and the physician, not just for a neat appearing record for the record librarian to file away.

Let me quote from an article in the *American Journal of Psychiatry* by Dr. Clarence O. Cheney: "I have thought for some time that perhaps because of our organization of a systematic record-making that the physician, unfortunately for the patient, may get the idea that the record is an end in itself and that making a record completes his observation of a patient and that the record assumes undue importance compared with the actual treatment of the patient." "There is and has been and will continue to be, the need of course, for making records, but unless the record is used for the benefit of the patient or for subsequent patients or for subsequent treatment by other physicians, the record does not make any difference to the patient himself or herself. I have felt that if physicians could feel that instead of having the main end job of making a record that they would get to know their patients, that the main aim would be to know their patients to discuss things with them, to sit down and talk to them in quite an informal, friendly way, without the idea in the physician's mind that he must make a record of anything that is done, that the patient might benefit by such an attitude on the part of the physicians."

The records should be looked upon as an assistance to the doctor rather than a cumbersome burden to be performed. The record librarian should take this into consideration when she completes the records for a patient's chart.

I would also like to quote from the discussion of the same article by Dr. Adolf Meyer: "I have lately gone over an article on statistics which shows a tremendous amount of work back of it and awfully few answers to the questions that I should like to ask. I, therefore, would suggest that for the benefit of the statistical department the cases should have

final summary concerning what the physician himself thinks that case is worth, in the way of teaching for the future, the grouping together of facts and the grouping together of problems." In other words, the records are only of value if they give us the picture of the patient as a whole and if they can convey to another doctor the essential factors and pertinent data regarding the patient who is under their care for a mental illness. Histories, then, do not have to be long and drawn out with a lot of unessential material thrown in to make the record look good. All patients do not need a consultation on the eye, ears, nose and throat, heart and lungs and abdomen. The psychiatrist himself should be able to make a satisfactory examination without the services of a consultant unless there is some specific illness involved for which the psychiatrist is not equipped or prepared to take care of. If we as psychiatrists are to see the whole problem then we should have a thorough knowledge of the other specialties and know when a consultation is important. If this were done more frequently I am sure we would not have the question asked as it is on many occasions, "Are psychiatrists doctors?"

In conclusion may I invite any of you who are interested to examine the psychiatric records which I have for exhibit. These records represent considerable effort on the part of the institution to abbreviate and make as easy as possible, for the physician, a record which will be accurate, statistically valuable and yet represent the patient in the correct perspective, also increasing the possibilities of a complete physical, mental and neurological examination for each individual patient. These records represent many years of experience in record keeping and are probably representative of the leading mental institutions in the country today.

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LOBOTOMY

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staff hamstrung by the usual public indifference as reflected in legislative inaction. All had been through shock therapy. Improvement in these patients has saved many civil service hours of work. Some have been discharged to home custody; others have been enabled to perform simple tasks of hospital maintenance or have been transferred from the disturbed section to easier surroundings. None are any worse off from the standpoint of society. A few succumbed to post-operative complications, which might have been avoided under better circumstances.

The burden of mental disease is borne by the family and the social group as well as by the individual so afflicted. We are seriously obligated to consider the patient first—but also the relatives and the tax-payer in any program of treatment. Lobotomy can help all three.

Prefrontal lobotomy has been referred to recently in a popular magazine that deals with LIFE in general as "a measure of desperation". I think it would be more accurate to call it a measure for the relief of desperation.

"The crucial decision must be made in each case as to whether a portion of the brain possessing some of the noblest functions of the personality must be sacrificed in order to restore the individual to a more effective existence, whether the effects of frontal lobe deficit will neutralize or accentuate the disharmony already present, whether the individual will be able to think more constructively with less brain at his disposal, whether the relief of the depression and its conversion into euphoria will permit of adequate social adaptation, and whether the individual so treated stands a better chance of survival in the highly competitive society of today than he would with intact frontal lobes and a potentially recoverable psychosis."

This statement was made by Walter Freeman, and I doubt that anyone could express it more effectively.

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THE MEDICAL RECORD

The necessity for medical records needs no justification. Good medical records, however, is a goal sought after not only by doctors, but by hospitals, nurses, jurists, and not least by patients. The distinction between a medical record and a good medical record is one that has slowly but progressively made itself felt. The personal professional experience of every doctor bears ample testimony of this. To the bedside notes of Hippocrates is given the honor of the first written medical record. So it has no claim to novelty. Only within the past quarter of a century has any organized effort by American Medicine been made to bring the medical record up to a level comparable with advances made in other branches of the art.

No more commendable objective could be cited. The responsibility on the part of the individual physician to fulfill this duty is pretty generally recognized. While perfection has by no means been attained, there exists an ever present and ever growing consciousness of the value of a good medical record to the doctor, to the patient, to medicine and its allied sciences and to society as a whole. In general it can be said that the status of the medical record is good and the impetus to achieve further improvement worthy of our never relenting support.

A long road has been travelled since the day that the progress of a patient's hospital stay was written in a bound ledger and filed away to gather dust. The modern medical records librarian supported by adequate personnel and an accessible library has marked the end of that era. Her place and importance in the present day hospital organization is sufficient tribute to the contribution she has made in emphasizing the value of the medical record. A suggestion of caution, however, appears indicated. From the level of national organization down to the small community hospital, the practicing doctor, who after all is the very essence of a good medical record, has recently become sensitized to a new element in alerting doctors to their responsibility about records. That element is pressure. It must be pointed out that any attempt at co-ercion, particularly when the means to that end is accomplished by the penalty of restricting staff privileges, is fraught with a genuine threat to the unity of our great profession so weighted by other controversies at this time.

There is absolutely no need for the adoption of such methods. It is readily admitted in all local hospitals as well as elsewhere that the standard of our medical records has markedly improved in the past five years. It is to the equal credit of the agencies sponsoring better records and the doctors that this achievement has resulted. The increasing scientific value of the medical record is now so readily appreciated by the average physician, it is certain that further progress will be made without resorting to penalty. Cognizant of the humaness of error and that some within our ranks may not

always produce a good medical record, nevertheless it is entirely unjustifiable, unethical and unmedical to impose or threaten to impose any staff restrictions upon the privileges of a member.

Let us not lose sight of the patient. It is obvious that there has been a tendency to confuse the importance of patients and records, perhaps not intentional but inevitable, in the enthusiasm that has attended efforts to make the medical record a good medical record. While the record was created for the patient, the latter is the pattern upon which the record must be tailored. Reliance upon the traditional integrity of every doctor of medicine will assuredly restore the patient to a position of primary consideration and at the same time not deny the record the relative importance with which time has finally endowed it.

MILLS OF THE GODS . . .

The medical profession of Rhode Island was the first to be involved in the complex problems of a compulsory cash sickness compensation program. Four years experience left us with many questions regarding the medical phases of such a plan still unanswered.

A year ago the House of Delegates unanimously adopted a resolution asking that the proper Council or Bureau of the American Medical Association make a study of the medical phases of existing and proposed cash sickness compensation plans, and to make such a report available by January, 1947. That resolution was placed before the AMA House of Delegates at San Francisco a year ago. A hearing was held on it by a reference committee, and the resolution was returned to the House of Delegates with recommendation of passage. The House adopted the committee report and the resolution without dissent.

Now, six months after the date when such a report was to be completed, we learn that the matter was not referred to the Council on Medical Service of the AMA until March, 1947! Meanwhile California is laboring under the machinery of a cash sickness compensation plan, and other states might have adopted such a program during recent Assembly sessions. The fact that other states didn't do so is poor justification for the delay in the study.

What is most significant now, however, is the fact that the new cash sickness benefit system for railroad workers goes into effect nationally this month, and every physician, other than those in Rhode Island, and possibly California, is going to learn what happens when a government agency challenges medical diagnoses and disability prognoses.

If the mills of the gods grind slowly, we can only hope that they always grind fine.

JOHN EDWARD FARRELL — DOCTOR OF SCIENCE

Dr. John Edward Farrell—thus, henceforth, we may, and assuredly we shall, address the versatile executive secretary of our society and the managing editor of this journal; for at its recent commencement exercises, Providence College, his Alma Mater, conferred upon him the honorary degree of Doctor of Science. To his many friends in the medical profession, which he now serves with such masterful energy, this recognition of his abilities and attainments is no less pleasing than it must be to the officers, alumni and friends of the college whose progress he has done so much to enhance. And while we are offering our congratulations to Dr. Farrell, let us not fail to pay the tribute of our grateful memory to the late Dr. William S. Streker who labored so long and so valiantly to persuade us that we require an executive secretary to assist us in the management of our affairs. While most of us were asleep, Dr. Streker was fully awake to the future needs and the expanding horizon of our profession, and to him is owing the presence in our midst of the dynamic Dr. Farrell.

Those of us who have observed with interest the developing career of John Farrell have often wondered how a man so young can have done so many things and done all of them so well. Indeed, it may with truth, be said of him, "In every work that he began . . . he did it with all his heart and prospered." But given native intelligence, a liberal education, a creative imagination, sound judgment and tireless effort, there is no field of endeavor from which one may not garner the fruits of honest work. And if, in the future, more honors are in store for John Farrell, as no doubt they are, we can be sure that they will come to him with no more sincere friendship and admiration than he already enjoys within the medical profession of Rhode Island. And so, once again, we congratulate Dr. Farrell and ourselves.

. . . Committee on Publication and Editorial Board

CENTENNIAL MEETING OF THE A M A

GUY W. WELLS, M.D.
Delegate from Rhode Island

THE CENTENNIAL CELEBRATION of the American Medical Association was held this year June 9 to 13, 1947, at Atlantic City. Those of us present who had access to the records could look back a hundred years and contemplate the wisdom of the founders and their early successors. The most visionary founder could not have contemplated, however, the One Hundredth Anniversary.

Atlantic City with its huge convention hall and many hotels, all convenient, is almost ideal for this convention generally, and especially this year. Never have so many doctors registered for a meeting—over fifteen thousand—and never has Atlantic City played host to so large a gathering. Atlantic City with its experience in such matters appears to be the only city that could hold such a large convention and with the untiring support of its medical profession formed committees to supervise nearly every phase of convention life.

The Woman's Auxiliary, a very active and important part of the American Medical Association from a functional viewpoint, also held its annual meeting at the same time. Not only their work and interests, but also their presence added a great deal to the success of the convention. This year, for the first time, Rhode Island had official representation in this allied meeting.

The convention hall was packed with both commercial and scientific exhibits, and the medical section alone usually drew more than two thousand doctors a meeting. Dr. Fishbein recalled to the writer that he remembered conventions not much larger than the medical section alone. Bigness or size itself is merely incidental. Secondly it indicates quality, for so many would not attend a mediocre scientific meeting. They were amply justified, for not only were our great medical men reading papers, but more than one hundred distinguished guests from foreign countries and universities were on the platform speaking of their experiences and discussing papers. The chief objective of the founders of the Association, medical education, was not only realized, but rededicated this year.

The House of Delegates met regularly from Monday to Thursday, inclusive, with the exception of one-half day, to permit interested Delegates more time to appear before Committees.

In keeping with the democratic plans of the American Medical Association it is interesting to note that a committee has worked for more than a year revising the Constitution and By-Laws. This revised form was presented to the House of Delegates and must lie on the table one year. During this time Delegates will have the opportunity to study it before a vote is taken to adopt or reject it.

The Committee on National Emergency Medical Service also reported. Their report discussed the nature of the part doctors must take in any future war. They recommended a permanent board for continual study of changing conditions, a permanent up-to-date classification of medical officers, and a better distribution of doctors between armed forces and civilian population, based on the needs of each, and a better system of rotation of doctors. In other words, a more accurate utilization of the medical profession based on a better understanding of the need.

The section on general practice received a good deal of attention, and it was recommended that such a section be established and represented by a Delegate. The representation will probably have to await the adoption of the new Constitution and By-Laws, but the section will have its program at the next meeting. It is quite likely that a mid-winter scientific regional meeting for general practice will be combined with the mid-winter meeting of the House of Delegates.

The complete business of the House of Delegates is recorded in the issues of the American Medical Journal and should be read by every doctor.

It was most gratifying to note the large representation of doctors from Rhode Island, perhaps the largest in history. Doctors Meyer and Elihu Saklad, and Dr. Priscilla Sellman, had an exhibit on Intraspinal Segmental Anesthesia. Dr. Meyer Saklad also discussed a paper given in the section on anesthesiology. Dr. Charles Bradley discussed a paper in the section of pediatrics. Dr. Francesco Ronchese won a first prize in the photographic section of the seventh annual exhibit of the American Physicians Art Association.

The officers for this year are:

President: Edward L. Bortz, M.D., Philadelphia, Pa.

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NATIONAL CONFERENCE OF MEDICAL SOCIETY OFFICERS

(Report by Daniel V. Troppoli, M.D., Secretary of the Providence Medical Association, of the Conference held at Atlantic City June 8, 1947.)

At the Conference of County Medical Society officers one of the first questions asked was whether any plans were being made for a specialty board for general practitioners who live up to progress in medicine.

This question brought forth a lively discussion that took up half of the time of the entire conference. Apparently this topic is uppermost in the minds of general practitioners throughout the country. Dr. R. L. Sensenich, Chairman of the Board of Trustees of the American Medical Association, felt that a specialty board for general practitioners was not the answer to this problem.

There are about 120,000 doctors not certified by any board.

Specialty boards were created to prevent men from setting up as specialists who did not have enough training. They did a good job in this respect. It was not intended that this set-up was to hurt the general practitioner who in some communities does all the medical work. To select out of this hundred thousand general practitioners another ten to twenty thousand as specialists will still leave ninety thousand who will be left out.

Ten years ago machinery was set up to have general practitioners continue postgraduate courses. Some of these courses were financed by outside agencies. Soon these courses were given by specialists outside the scope of the work of the general practitioners, so this did not work out so well.

As a result, however, a physician was added to the staff of the Council on Education and Hospitals. The states did not cooperate with this movement as well as the A.M.A. would have liked. The matter has been submitted to the Council on Education and they will return plans to set up proper courses in the states. Furthermore, recognition will be given for these, and the men will be rewarded by proper credit.

Out of all this may come a unified program which will give equal opportunity to every man in the profession.

Recommendations are already accepted that training is more important than board certification.

The whole subject of medical education should be reviewed. These plans are now underway. Taught by specialists in medical schools, internes in straight service hospitals take residencies in their specialty and then become board members. They have no broad experience. The whole teaching system has to be changed to correct this. Last year the delegates to the American Medical Association passed a resolution that, "Hospitals should have general practitioner sections."

A group in the audience felt that many men who might have gone into general practice would be forced into the specialist group and that a great shortage of general practitioners would result from this.

Every student in medical school has the thought of specializing at some time. In the past he entered general practice first. Many of these practitioners liked what they were doing and continued in it. Others finally after a period of broad experience in general practice went into specialties.

Los Angeles County solved this problem in this manner: The general practitioner group is divided into three categories,

1. *General Practitioner Surgeons.* Men whose record over a period of years showed them able to do major surgery.
2. *General Practitioner Internists.* This group included men who showed ability as diagnosticians.
3. *General Practitioner Group.* These men are not allowed to do major surgery. They are also supposed to call in medical consultants in complicated cases of medicine.

Many felt that the main problem is a shortage of hospital beds. The problem can only be solved by adding hospital beds. Even the prepayment plans won't work unless the beds are available for these patients. The Hill-Burton Bill provides for an annual appropriation of seventy-four million dollars for increasing hospital facilities.

Some of the men present felt that the boards are glorifying the specialist so much that the name "general practitioner" now seems to have a stigma attached to it. This feeling was so great that suggestions were made not to use this term any longer, but to use the term "general physician" or "family doctor."

* * * * * * *

continued on next page

Dr. L. W. Larson, Member of the Committee on Rural Medical Service, led the discussion on Rural Health.

At least five or six states have formulated definite plans to have rural health conferences. How can young physicians be induced to settle in rural areas? We all recognize the shortage of doctors in rural areas. The local granges recognize this problem and are making good inducements to young doctors to settle in such communities. They know that doctors want good facilities to work with, so local areas are now developing small hospitals for this purpose.

Medical schools now are placing more emphasis on rural practice than formerly. The tendency of rural hospitals to extend their facilities to surrounding rural doctors is also an advance.

All rural county medical societies should do something in this work. They should influence bright country boys to study medicine and practice in their home localities. A local council on health should be formed by rural medical societies and this council should consult with the town or county authorities on these problems. Also, the larger centers should have more contact with rural practitioners.

County medical societies should present subjects that are of interest to the country practitioners. At present some of the groups put on subjects of too scientific a nature that do not attract the rural doctors.

Dr. Norman Scott, Medical Director, Medical-Surgical Plan of New Jersey discussed prepayment medical plans for rural areas. Since these prepaid plans must necessarily work with groups, the rural groups must be well organized. These groups could include farm cooperatives, farm bureaus, and farm granges. As a matter of fact whole rural communities could be enrolled. The Louisiana Surgical plan is incorporating whole rural communities.

* * * * * * *

Dr. A. M. Mitchell, of the Council on Medical Service of the American Medical Association led the discussion on Public Relations. He submitted a report on the medical public relations in the District of Columbia as an example. This report showed that in 1940 the District of Columbia Medical Society devoted 10 per cent of the time to medical relations. Now it is putting in 25 per cent of its time to medical relations to keep the doctors informed, because if the doctors do not know, they cannot spread the information to their patients.

Medical publicity involves proper relationships with the newspapers. The medical profession needs the cooperation of the newspapers. Releases for the newspapers should be prepared to avoid misquoting. This method also furnishes the reporter with information to answer his questions.

Avoid unnecessary controversies, particularly small petty ones. In their legislative programs the societies must have enterprise, friendship, vision, courage, and leadership.

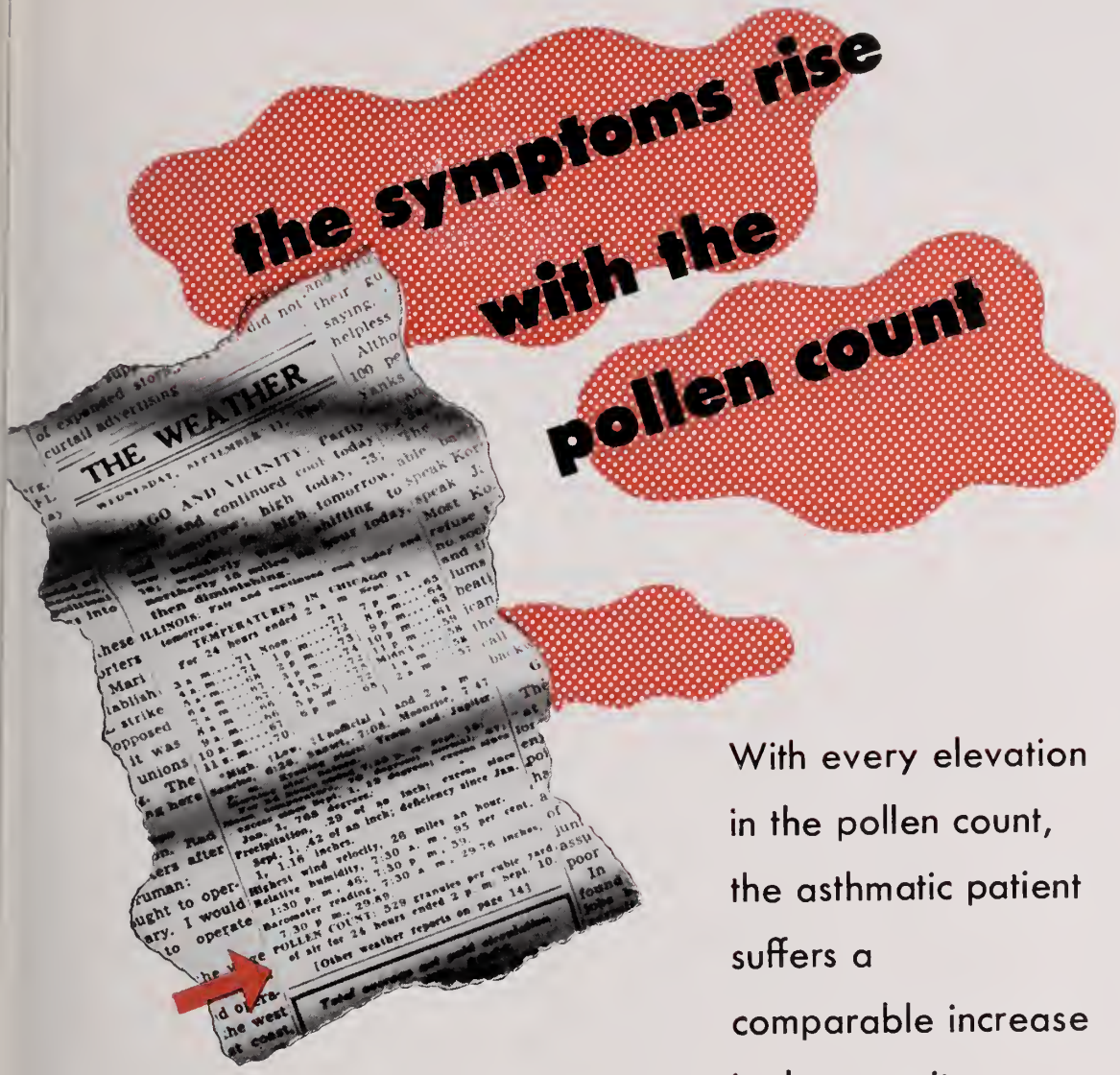
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The American Medical Association Committee on Motion Pictures sent an announcement that medical and health films of the A.M.A. are loaned to county medical societies on request. The only charge made is for transportation. They also have a series of health films to be shown to lay audiences. They have a source list at A.M.A. headquarters, and a letter to them will tell any doctor where he can get the desired film.

The reviews of motion pictures which have appeared in the Journal of the American Medical Association will soon be published in booklet form and sent to local medical societies. They describe the length, content, quality, and subject of the film. A film forum will start this fall at the A.M.A. Three or four films a month will be previewed by teachers and these reports will be transmitted to state societies.



This sunset on the Canadian vastness, taken by Dr. F. Ronchese, July 16, 1946, from the eastbound observation car, won first prize at the 7th annual meeting of the American Physicians Art Association, held in conjunction with the centenary celebration of the American Medical Association, Atlantic City, June, 1947.



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THE EDUCATION OF THE NURSE

The following discussion of the education of the nurse offering some interesting observations on the nurse problem of today was submitted by a Rhode Island physician with a deep background in medical and nursing problems in this State for many years. The Editors considered the communication an excellent presentation worthy of general reading, and therefore publish it with the permission of the author, but with his name withheld from the title heading.

—The Editors

THE REPORT on the "Nursing Problem" by a Special Committee of the American Surgical Society, published in the A.M.A. Journal (April 12th—page 1168) with editorial comment, deserves notice in all Medical, Hospital, Nursing, and indeed lay press of the country. It is a convincing statement, to which we refer every one interested for careful study.

The Report states simply, clearly and temperately, the basic causes to which may be credited, in large part, the present dearth of nursing personnel, with its definite drop in morale and efficiency, from which the Hospitals and public now suffer. Its final Resolution is to the point and will help to meet the *present* situation, i.e., "Resolved that it urge the immediate establishment of short courses for the training of bedside nurses".

However, we believe this Report, with its clear discussion of the subject, opens the way for possible action in correcting, not only the present difficult nursing problem, but the mistaken trend in nursing education which has existed for many years past, that over-emphasis of "intellectual and scientific" rather than common sense, practical training for those who would follow this noble profession.

Several National Nursing Groups (named in the Report) which for years past have controlled nursing education and so the Nursing Schools in this country, have so exaggerated this "intellectual" requirement of the profession that they have well nigh lost sight of the primary, human, practical purpose for which the nurse is trained and needed, i.e., the bedside care of the sick patient. They have striven to persuade Hospital, Nursing Schools and personnel, and finally themselves, that nursing is one of the learned professions, which it is not and should glory in not so being, since it is one of the great humanities.

As a possible solution of this problem, becoming ever more serious as time passes, we offer the following, well realizing that a start made now can produce results only in the distant future:

Establish in the Nursing Schools a basic course of 1½ years for all pupils, upon the satisfactory completion of which the student graduates with a diploma (R.N.). We emphasize a "single" basic course, as we are convinced 2 courses, one short for so called bedside nurses and another longer for R.N's. in the same School would be complicated, confuse the public and not be satisfactory. Also do we believe that a good practical 1½ years course for students of high school diploma grade, is long enough to train them for the duties required of the R.N. Such a course will be devoted largely to practical instruction in the care of the sick medical, surgical, and other patient, with all that this implies, and with a minimum of didactic work. From this whole undergraduate body of students, some will decide they wish to go further and specialize in a branch of nursing which appeals to them, such as Surgery, Obstetrics, District, Industrial or Mental work; these students will be required to study for another six months or perhaps a year.

To enroll in this advanced course, the requirements should be *very* strict; broadly speaking, an exceptionally fine record in the regular 1½ year course with definite promise of success in more specialized work. Such restriction would eliminate mediocre personnel in those advanced nursing groups, which bear the burden of responsibility in specialized branches of the profession, as well as in nursing education. To such nurses a second diploma should be awarded (R.N.S.S.—Special Surgical, R.N.S.N.—Special Neurology) and they would command higher pay.

It is agreed by many experienced physicians as well as nursing superintendents, etc., that the periods of time, above suggested, should be sufficient for basic training in the two grades of nurses as described. Finally, there should be no grade of nurse other than the two above described recognized or certified by the State authorities.

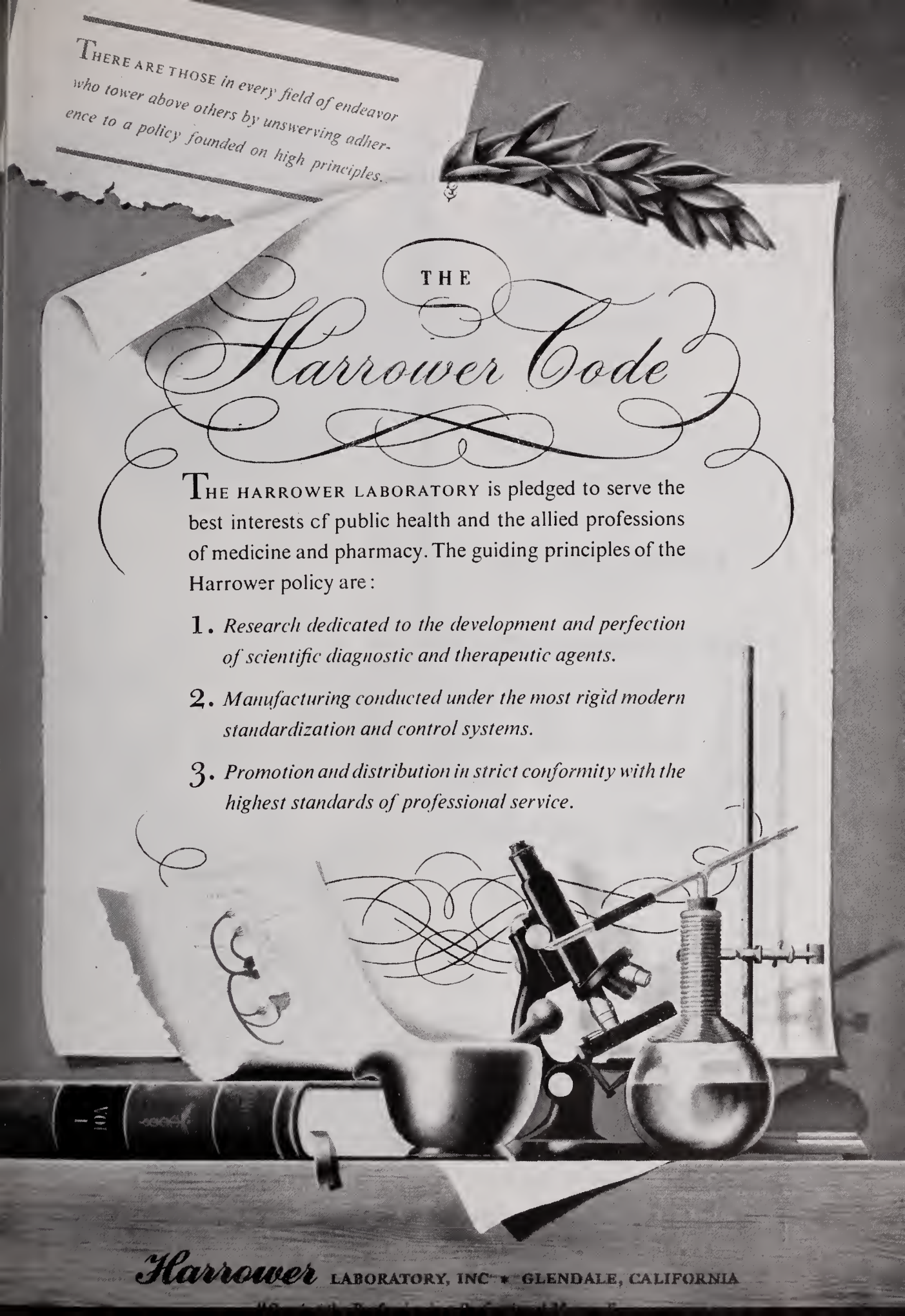
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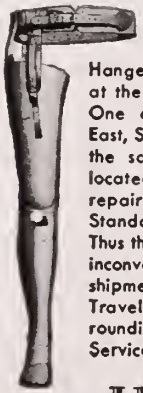
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EDUCATION OF THE NURSE

concluded from page 526

It seems that such a plan would present several advantages—

(1) It would attract more young women than at present to the Nursing Schools. (Many now are deterred by the prospect of three years of training.)

(2) It would relieve the student of much present didactic study, unnecessary and quickly forgotten, and so give more time for instruction in caring for the sick patient at the bedside.

(3) It would stimulate ambition to become an advanced student.

(4) It would enable the advanced student to concentrate on the specialty of her choice and become truly expert.

(5) It would eliminate the present unsatisfactory and confusing situation of several grades in nursing service, i.e.—R.N., Practical Nurse, Nurses' Aides, and perhaps others whose specific duties are now a matter of debate.

It is manifest that the large group of so called Practical Nurses (many of these excellent) now actively working, would not come under such a plan, unless they enter for the 1½ year course in a nursing school, for which many would be beyond the age limit. For such, special provision should be made.

The several dominant national nursing groups, referred to above, would probably oppose such a plan, but should be urged to consider it in a co-operative spirit.

If, as is doubtless the fact, the Reporting Committee of the American Surgical Society is correct in stating that "doctors, hospital superintendents, etc." are in favor of a short practical course for R.N's. they should influence the Nursing Schools to offer such a course, without approval of the National Nursing bodies, if such cannot be gained.

We here preach not revolution but evolution, a non-conformist doctrine if you will, but one long in the minds of the best informed people. Where better than in this little historically non-conformist State of Rhode Island to bring it into the open and so start a move for bigger and better nursing.

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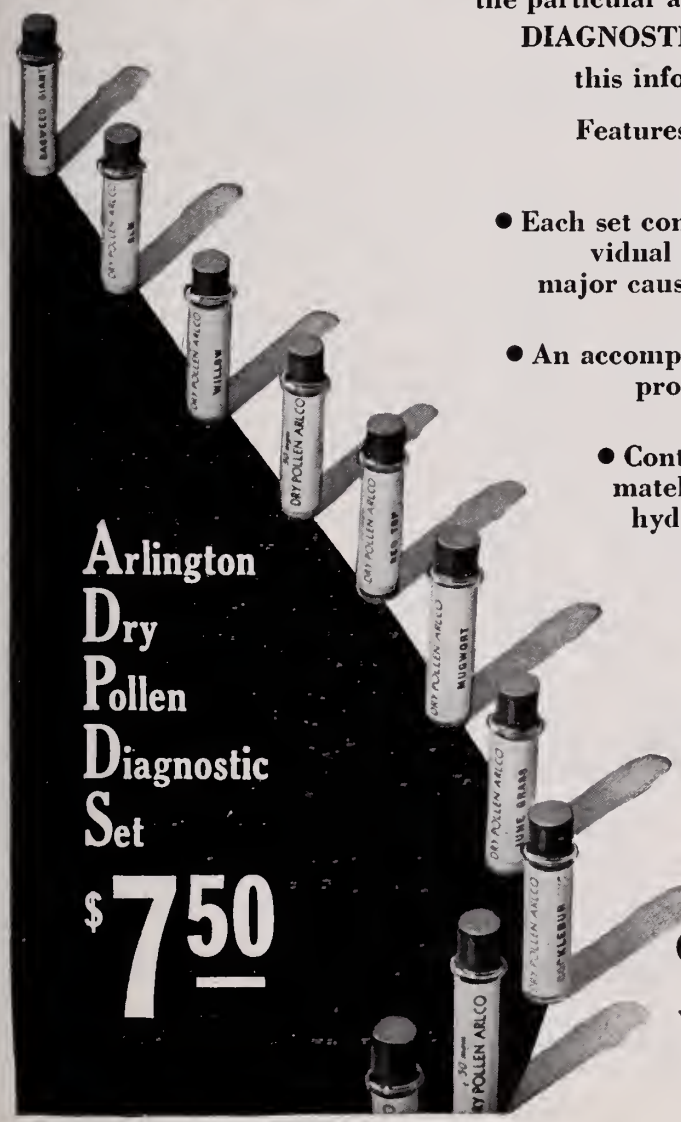
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CASH COMPENSATION PLAN FOR RAILROAD WORKERS

(All physicians should read this brief report on the plan started July 1 for railroad employees as the program entails medical certification of any disability, as in the R. I. Cash Sickness plan.)

RHODE ISLAND physicians, already educated to some extent to the system of cash sickness benefits as the result of the operation of the Rhode Island Cash Sickness Compensation plan, now face another similar program for railroad workers.

Effective the first of this month operation was started in accordance with amendments made last year to the Railroad Unemployment Insurance Act whereby partial compensation for wage loss due to disability on the same basis as that due to unemployment will be available for more than two million railroad workers throughout the country. The system is administered by the Railroad Retirement Board which administers the entire railroad unemployment insurance program.

The fund from which payments will be made is created by the railroads, and the plan will be somewhat of a mail order insurance in that all claims for benefits have to be filed at the board office in New York within nine days from and including the first day the claimant is unemployed due to illness. The railroad workers are not under any other program, such as the Rhode Island unemployment and cash sickness plans.

Medical Certification

As is the case with the Rhode Island cash compensation plan, the railroad worker must secure himself the proper forms from his employer (the railroad) and must have a medical examination by his personal physician completed as part of the requirement for benefits. The railroad worker continues as any other private patient of the physician and the railroad retirement board makes no provision for the payment of the physician's fee for the medical examination.

The physician fills out the medical certification form for the patient who must in turn submit the complete form to the Railroad Retirement Board in New York City within 9 days from the onset of the disability, otherwise his eligibility for benefits is jeopardized. In view of this ruling every physician should, whenever possible, allow the patient to send the medical form which is attached to the complete form to be filed, as otherwise there may be inadvertent delay which may prove costly to the patient-claimant. However, if the physician does not wish the patient to have the medical report and diagnosis, then he should detach it from the form and mail it directly to the board office himself.

As is the problem with the Rhode Island Cash sickness medical certification, the physician is faced with the task of providing a disability prognosis. After the initial claim additional benefits may be allowed for succeeding 14-day periods for a predetermined time as indicated by the medical evidence on the doctor's initial statement. But in the case of continuing illnesses supplemental information about the patient's illness may also be requested from the physician.

When the Board has occasion of question the medical certification it reserves the right to refer the claimant to an impartial medical examiner. Three such examiners have already been designated for Rhode Island.

Additional information about the program may be secured by any physician from the Railroad Retirement Board, 1802 P.O. Bldg., Boston, Massachusetts.



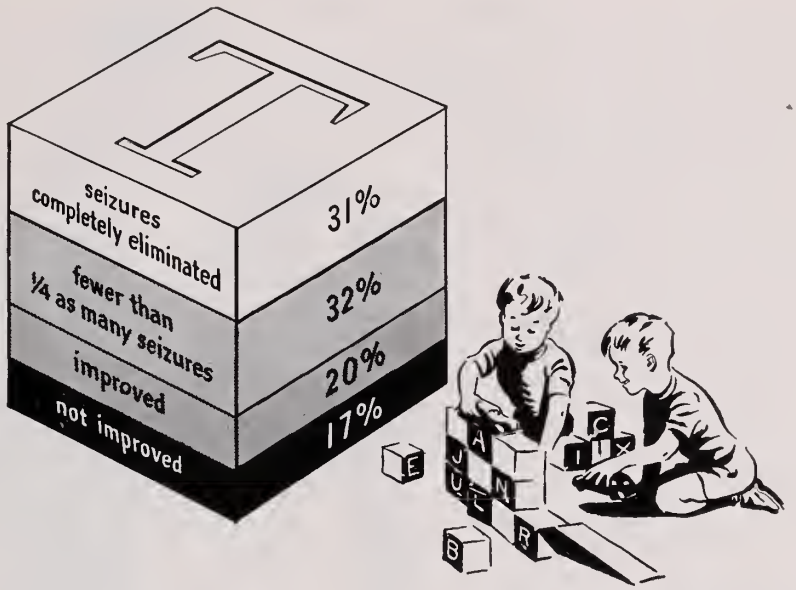
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83% of petit mal cases improve with Tridione

BIBLIOGRAPHY

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Here's new evidence of the effectiveness of Tridione in the treatment of petit mal. In a recent study, Tridione was given to 166 patients suffering from petit mal (pyknoepilepsy), myoclonic jerks or akinetic seizures.[13] This group as a whole had received but mediocre benefits from other medicaments. With Tridione, 31% of the 166 became free of seizures; 32% had fewer than one-fourth of the previous number of seizures; 20% improved to a lesser extent; 13% remained unchanged, and only 4% became worse. *Thus 83% showed improvement.* In some cases the seizures *did not return* after Tridione was discontinued, the longest seizure-free period thus far being 18 months. Studies also have shown that Tridione is of benefit to certain psychomotor patients when given in conjunction with other antiepileptic drugs.[12] Tridione is available through your pharmacy in 0.3-Gm. capsules and in pleasant-tasting aqueous solution containing 0.15 Gm. per fluidrachm. Capsules in bottles of 100 and 1000; solution in 1-pint and 1-gallon bottles. If you wish to know more about Tridione, just write to ABBOTT LABORATORIES, North Chicago, Illinois.

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CASH SICKNESS BENEFITS

(From supplementary report of the Council on Medical Service to the House of Delegates of the American Medical Association)

A STUDY of cash sickness benefits was authorized in July, 1947, but was not referred to the Council until March, 1947. The Council has inquired briefly into the status of disability insurance providing temporary cash benefits for time loss due to non-occupational disabilities. We find that there is much controversy concerning this type of insurance, particularly when it comes about as a result of either federal or state legislation. At the present time two of the states, Rhode Island and California, have adopted compulsory disability benefit laws. In general they follow the same pattern. They differ, however, in that Rhode Island sets up a monopolistic state fund for the purpose of supplying benefits, while the California law permits either the employer or a group of employees to establish a voluntary plan as a substitute for coverage under the state plan. Many defects seem to have become apparent in the Rhode Island program, and it seems to be the consensus that it provides only a negative lesson in that it shows certain features not desirable in a law but gives no experience to prove that even with these eliminated, its operation would be satisfactory. The California plan has not provided sufficient experience to determine its worth.

The Council finds that some thirty-two "cash sickness" bills have been introduced this year in the legislatures of thirteen states. Twenty-two of these bills have failed to pass, one passed both houses but was vetoed by the governor, and nine are still under consideration.

The Council also points out that the action of Congress in amending the recent provision of the Railroad Retirement Act to provide disability benefits for railroad employees will likely serve to focus and intensify the interest of state legislators in compulsory disability benefit laws. There has, of course, been a rivalry between the state and federal governments in the field of unemployment compensation benefits and a renewed drive for state legislation may well be expected. If this drive materializes the state medical societies will need aid in devising policies and this will require a knowledge of developments under existing programs.

We must not forget that this type of compulsory program may well lead to expansion of social security legislation along the lines suggested by Senators Murray and Wagner and Representative Dingell. Therefore, its benefits and defects must be reviewed in the light of principle as well as temporary accomplishment. The Council mentions this preliminary study of cash sickness benefits to call attention to its importance and to inform the Delegates that a detailed study will be made so that the State Medical societies will be in a position to meet possible future legislation.

VETERANS' ADMINISTRATION HOME TOWN MEDICAL CARE PROGRAM

UNDOUTEDLY most of the Delegates are aware of the Veterans' Administration Home Town Medical Care Program. Under this program the veterans were to receive medical care for service-connected disabilities from physicians of their own choice, physicians were to serve for fees agreed upon through their state medical societies, and every effort was to be made to provide the veterans with the same medical care received by civilians. Up to the present time some thirty-eight state medical societies have worked out agreements with the Veterans' Administration for the purpose of providing the veteran with the same care he would receive as a private patient. To this decentralized, free choice program the Veteran's Administration agreed.

There are now indications that new factors have arisen that have resulted in the Veterans' Administration altering its policy. It would seem now that its policy is to set up more and more clinics manned by Veterans' Administration doctors, and require veterans to go to such clinics

continued on page 536



Menopausal Relief... **Plus** A General Sense of **Well-Being**

There is usually a "plus" in the treatment of the menopause when "Premarin" is employed. The "plus" is the gratifying "sense of well-being" so many women experience following orally active "Premarin" therapy. It is the intangible factor which, added to relief of distressing symptoms, enables the middle-aged woman to resume her normal routine of useful and enjoyable occupations.

To permit flexibility of dosage and enable the physician to adapt oral estrogenic therapy to the particular needs of the patient, "Premarin" is supplied in three potencies:

Tablets of 2.5 mg. . . . . bottles of 20 and 100.
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Liquid, containing 0.625 mg. in each 4 cc. (1 teaspoonful)—bottles of 120 cc.

While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens . . . estradiol, equilin, equilenin, hippulin . . . are also present as water soluble sulfates. The water solubility of conjugated estrogens (equine) permits rapid absorption from the gastrointestinal tract.

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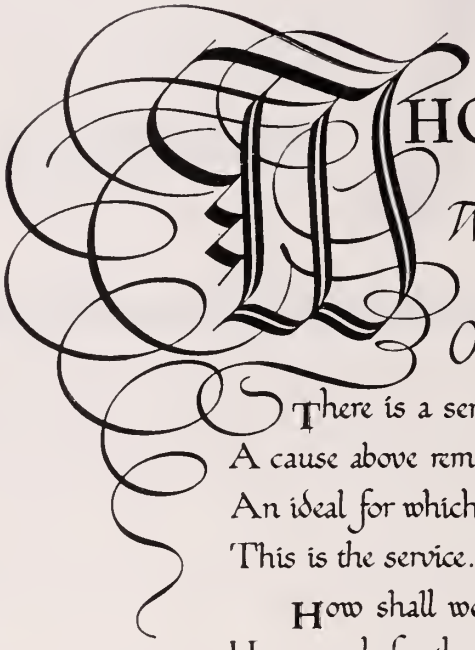
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There is no algebra for it, no scribble of figures, no proper value.
For this is a service as large as life, and as manifold.
It is a soldier crying in agony on a thousand battlefields.
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It is Hope.
It is the lonely, unending quest for knowledge.
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It is the dumb, unspeakable joy in the eyes of a parent.
It is the rock of grief.
It is cold rain and pounding storm and bone-weariness and the new-born babe gasping its first breath in the grey dawn.
It is all this, and the quiet glory of the job done,
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VETERANS HOME TOWN CARE

concluded from page 532

where available. Further, the Veterans' Administration has prepared a schedule of fees, which while supposedly an attempt to arrive at a standard nomenclature, does contain a maximum fee for each service and has all of the ear-marks of a nationwide schedule of fees.

The Council recommends to the House of Delegates:

1. That the Council on Medical Service be authorized to set up a conference for the purposes of arriving at a definite policy with regard to the Veterans' Administration Home Town Medical Care Program.
2. That representatives from each of the state medical societies and representatives of the Veterans' Administration be invited to this conference to present their views, experiences and opinions.
3. That following this conference, the Council on Medical Service in collaboration with the Board of Trustees and representatives selected by the State societies be authorized to meet with representatives of the Veterans' Administration to effect solution of any existing problems.

NATIONAL ESSAY CONTEST

Announcement has been made of the winners of the Association of American Physicians and Surgeons' National Essay Contest for Junior and Senior High School students on the subject, "Why the American System of the Private Practice of Medicine Gives the Finest Medical Care the World Has Ever Known." They are as follows: First prize of $1,000 awarded to Miss Jean Downhour, Benchland, Montana; Second prize of $500.00 awarded to Dick Brandow, Bradford, Pennsylvania; Third prize of $100.00 awarded to Miss Bettye Eccles, Gulfport, Mississippi.

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The well-balanced, rational formula of Livitamin With Iron is designed to combat the many manifestations of the protean syndrome characteristic of hypochromic anemia. It provides not only highly available iron in nonionic form, but also generous quantities of B complex vitamins as well as fresh liver (as liver concentrate) containing the fraction in which the recognized antianemia principle is found. Thus existing vitamin deficiencies, so often the cause of anorexia and nutritional involvements, are promptly overcome, further adding to the patient's subjective improvement as the anemia itself is corrected.

Livitamin With Iron proves highly efficacious in all types of secondary anemia, whether due to impaired iron intake, chronic blood loss, or chronic systemic infection. It is especially valuable in the anemia of children which is so often associated with malnutrition and vitamin deficiencies. Dosage: 3 to 4 teaspoonfuls three times daily.

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Iron and Manganese Peptonized	30 gr.
(Equivalent to 45 mg. elementary Iron)	
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Thiamine Hydrochloride (B_1)	10 mg.
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Nicotinamide (Niacinamide)	25 mg.
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Liver Concentrate 1:20	45 gr.
(Represents 2 oz. fresh liver)	
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SEMCO

HOSPITAL ASSOCIATION OF RHODE ISLAND

REPORT OF ACTIVITIES

Furnished by the Staff of the State Hospital for Mental Diseases

Hospital Association Meeting

The June meeting of the Hospital Association of Rhode Island was held at the Westerly Hospital. Preceding the business meeting, Miss Helen M. Blaisdell, Superintendent, conducted the members through the Hospital. The members of the Association were served a delicious shore dinner at The Willows, in Charleston, following the meeting, as guests of Miss Blaisdell.

Medical Staff Changes

Dr. John A. Paterson, Senior Physician on the staff of the State Hospital for Mental Diseases for the past eight and one-half years, resigned as of June 15th to accept a position on the staff of the Veterans Administration Hospital at Togus, Maine. Dr. George L. Wadsworth, former Assistant Superintendent at the State Hospital for Mental Diseases, has been Clinical Director of the Neuropsychiatric Service at the Togus Veterans Hospital since November, 1946.

School of Nursing

On September 1st, 1945, the State Hospital for Mental Diseases School of Nursing received the first class of student nurses for a thirteen-weeks course in psychiatric nursing. The course has continued, except for one period due to the absence of an Educational Director. There are eleven students in the present class—three from the Memorial Hospital, Pawtucket; three from the Newport Hospital; and five from the Roger Williams General Hospital. It is planned to gradually increase the number of schools represented and the total number of student nurses enrolled.

New Pay Plan

A new salary schedule for State Civil Service attendants and nurses has been effective since February 16th. Starting July 1st the majority of the other State employees will receive salary increases under a new pay plan developed by the State Department of Civil Service. Incorporated in the new pay plan is a new maintenance plan under which all items of maintenance will be paid for on a cash basis, following a schedule of values developed by the State Department of Civil Service and the State Department of Finance.

Hospital Survey and Construction Act

The Governor has signed the State Hospital Survey and Construction Act which carried an appropriation of $10,000. Provisions in this bill are in accordance with the requirements of the Federal Hospital Survey and Construction Act.

World War II Veterans

A recent study of admission of World War II veterans to the State Hospital for Mental Diseases reveals that 173 veterans have been committed to the Hospital and that all except 44 have been released, including 34 for transfer to neuropsychiatric hospitals for veterans. Of the 129 released from the Hospital, 17 have been recommitted. There have not been any deaths in this group, as might be expected of patients in this age group.

Summer Workers

The Unitarian Workcamps, of Boston, Massachusetts, have added employment at the State Hospital for Mental Diseases as one of their service projects for college students, applicants being accepted on the basis of genuine interest in hospital work. The work camp offers a balanced program of work, education and recreation. It is nonsectarian and interracial. Similar work camps have been sponsored by the Mennonite Church Agency in recent years, and their assignments at the State Hospital for Mental Diseases have been highly successful.

Admission and Release of Patients

The majority of patients at present come to the Hospital on a Department of Social Welfare order. Applications for admission are completed by two licensed physicians and a member of the family. These are submitted to the Department of Social Welfare, 40 Fountain Street, Providence, Rhode Island. An order is issued which authorizes the Hospital to receive the patient. This is brought to the Hospital with the patient by the family. Such application forms are available at the Department of Social Welfare, Providence, at the State Hospital and in the office of the Director of Public Welfare in most communities.

There is a growing trend to admit patients on a voluntary basis. Any person who comes to the Hospital requesting treatment is eligible for admission on a voluntary basis if he shows knowledge

continued on page 540

On the Plus Values In Variety Meats

Variety meats—as the meat industry terms liver, kidney, heart, thymus (sweetbreads), and tongue—are at least as nutritionally desirable as muscle meat. In fact, in some respects certain organ meats are superior.

They provide the indispensable amino acids in the same advantageous complete assortment as muscle meat. Hence their protein is of the same high biologic value, capable of meeting every protein need of the organism. Quantitatively their protein content is approximately equal to that of muscle meat.

For hemoglobin synthesis, liver and kidney have been found superior not only to all other protein sources so far studied but also to muscle meat itself.

All organ meats are good sources of the B-complex vitamins. Some of them, such as liver and kidney, are especially rich in niacin. Liver is also an excellent source of vitamin A.

Apparently the vital role these organs play in the functioning of the animal body is reflected in the valuable contribution they can make to human nutrition. Their frequent inclusion in the human dietary—during disease as well as in health—is amply justified.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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HOSPITAL NOTES

concluded from page 538

of the nature and location of the Hospital and is willing to sign an agreement that he will give notice in writing three days before he leaves. Voluntary admission is encouraged whenever possible, as this enables the patient to feel that he is an active participant in the treatment plan.

A District Court commitment frequently constitutes the most expedient means of arranging for admission of a patient who has shown behavior disturbing to the community. However, with patients whose behavior has not led to contacts with the police it is desirable to avoid a court commitment. Department of Social Welfare order or voluntary admission enables the physician to arrange for hospital care without the need of a court contact, which is greatly resented by many patients.

During the year, July 1, 1945, to July 1, 1946, 827 patients were admitted. Department of Social Welfare orders accounted for 515, District Court commitments for 237, voluntary admissions for 61, Superior Court commitments for 10, and voluntary narcotic admissions for 4.

Release from the Hospital is at the discretion of the Superintendent. In practice, a patient is released from the Hospital whenever the maximum benefit from hospital care has been achieved or when a suitable plan for his care is worked out with the family. This may be in the home of a relative, in another hospital, in a convalescent or boarding home. It does not depend upon complete recovery. The family's request to remove a patient is rarely refused. This is done, however, when necessary to protect the patient or others from serious results of irresponsible behavior. During the year, July 1, 1945, to July 1, 1946, 721 patients returned to the community.

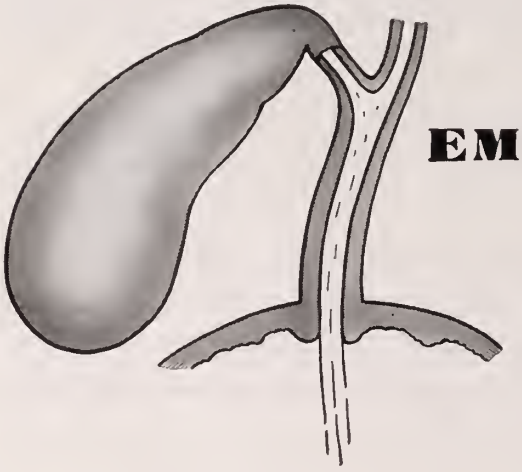
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CARTOSE supplies nonfermentable dextrins in association with maltose and dextrose . . . a combination providing spaced absorption that minimizes gastrointestinal distress due to fermentation.

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ANNUAL REPORTS — 1946

THE RHODE ISLAND MEDICAL SOCIETY

ANNUAL REPORT OF THE SECRETARY — 1947

In view of the fact that the membership of the Society has been fully informed through the JOURNAL of the society of all actions taken by the House of Delegates, and of important committee actions, a resume by the Secretary of the activities may rightfully be omitted from this report.

During 1946 the Society attained its highest enrollment in its history with a total of 761 Fellows on the roster. This consistent growth in membership at a time when organized medicine is faced with many vital problems may be taken as evidence of the increasing interest and support of the many activities of the Society in behalf of the profession and of the public generally.

The Council has met regularly and has given conscientious consideration and study to every problem placed before it. It has served as the clearing house for the many activities carried on by or referred to the Society.

The Board of Trustees, with approval of the Council, effected needed repairs to the Library building and purchased fire insurance consistent with today's valuation of the building and contents.

The executive office continued its invaluable assistance to the officers, the Council, House of Delegates, and the various committees of the Society, in addition to the many services it has rendered to individual members, and to the public.

Respectfully submitted,

MORGAN CUTTS, M.D.

May 7, 1947

ANNUAL REPORT OF THE TREASURER — 1946

The complete record of all the finances of the Society, and the disposition of all funds, constitutes the actual report of the Treasurer. However, as a mere recital of figures in balance might prove tedious reporting for you to hear, I offer this brief summary by way of explanation of the work of the Treasurer for the Society. The complete statistical report is available, and I shall be pleased to read it in detail if it is the wish of any member of the House.

Summary of 1946 finances:

The Society started the year with a cash balance of $6,807.01.

Receipts, including annual dues, payments for exhibit spaces at the annual meeting, advance payments on 1947 exhibit spaces, contributions from the Providence Medical Association, and miscellaneous donation (use of building, etc.) amounted to $21,948.85.

To meet the cost of necessary repairs to the Library building, as approved by the Council and carried out by the Board of Trustees, a total of more than $8,300 was added to the General Fund by transfer from the JOURNAL Fund, the Endowment Fund, and a Participation Account established in 1934.

Thus the total funds created over the year into the General Fund amounted to $35,167.19.

Against this a total of expenses of $29,100.62 was paid out, leaving us at the end of 1946 with a cash balance of $6,066.57, which is slightly less than we had as cash assets at the beginning of the year.

I would particularly call to the attention of the House of Delegates the fact that for the first time in many years the Board of Trustees has been able to make needed repairs to our building. A careful appraisal of the building by our architect revealed some very serious construction problems that entailed costly repair. The entire roof had to be repaired, the brick pointed, and every precaution taken to offset the damages of years standing, damages which resulted in leaks that caused disfiguring of the auditorium and the book stack walls. The exterior, as far as the roof is concerned, is now in good condition. Also, the auditorium has been painted.

In addition we have had a careful re-valuation of our property and have purchased insurance to protect the Society against fire and other hazards to our property. The sidewalk about the building, put in two years ago, entailed another expense against the 1946 account. These three items alone, repair, insurance, and the sidewalk, aggregated more than $7,100.

To meet these expenses our Endowment Fund has been depleted except for some stock amounting to $2,100 in value. The Participation account, so called, a reserve fund set aside in 1934, has been used, and the reserve fund of the JOURNAL has been heavily drawn against.

continued on page 544

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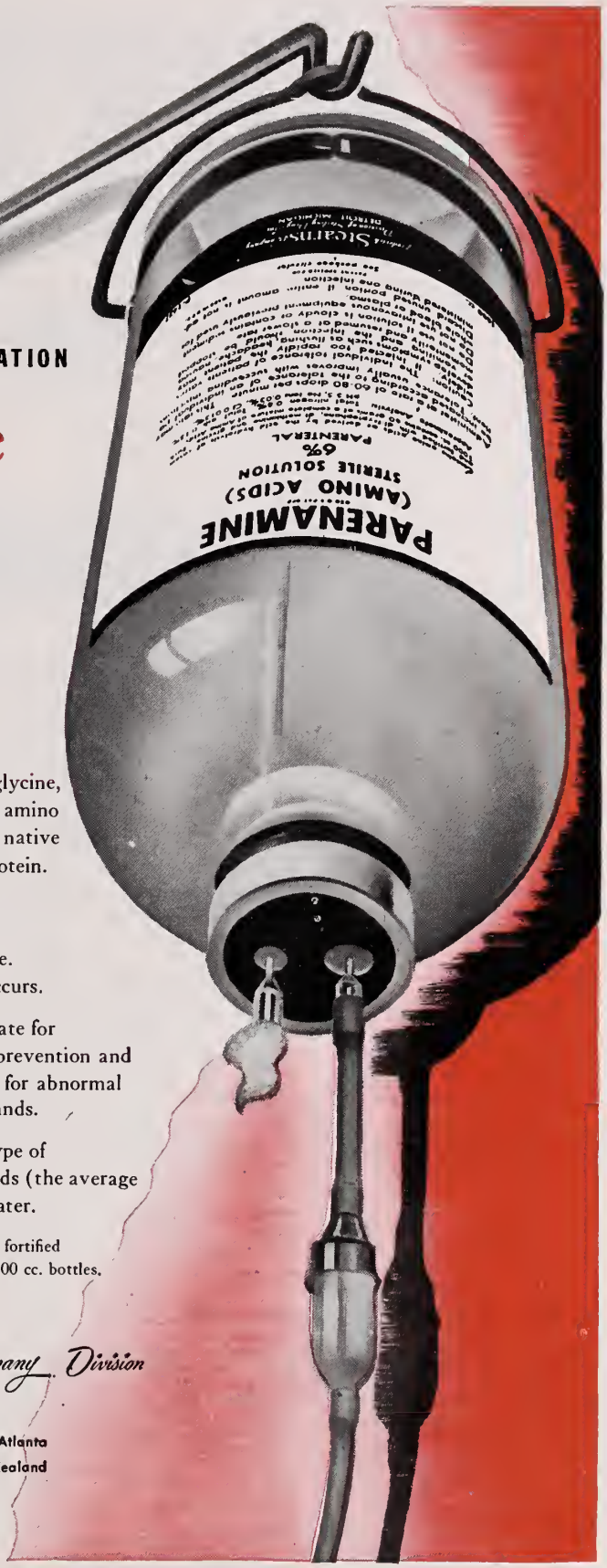
An improved acid hydrolysate of casein, fortified with *dl*-tryptophane, *dl*-methionine and glycine, PARENAMINE 6% is a complete mixture of all the amino acids essential for humans plus other amino acids native to casein . . . an excellent substitute for dietary protein.

Sterile, pyrogen-free non-allergenic, pH 5.5, PARENAMINE 6% has an exceptionally low ash (sodium ion) content and is virtually chloride-free. Clinical studies indicate that thrombosis rarely occurs.

FOR USE whenever dietary measures are inadequate for maintaining an optimal nutritional status . . . for prevention and correction of protein deficiency . . . to compensate for abnormal losses of body proteins . . . to fulfill increased demands.

SUPPLIED in one-liter bottles, adaptable to any type of intravenous delivery set-up . . . 60 Gm. of amino acids (the average adult daily requirement) in 1000 cc. of distilled water.

PARENAMINE 15%—acid hydrolysate of casein fortified with *dl*-tryptophane—continues to be available in 100 cc. bottles.



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TREASURER'S REPORT

continued from page 542

As a result the Council named a committee of its members to study the future needs and the financial policies of the Society. On the basis of the report of that Committee it was recommended that the dues for 1947 be $40.

At the present time when this report is being submitted to the House, the Board of Trustees is securing bids for the painting of the reference room and the stair halls, as well as the Miller Room and the executive offices, and it is also securing estimates for new lighting in the Library to replace the present fixtures. It also hopes to improve the facilities of the Reference room for the benefit of the membership of the Society.

The interest from the various Special Funds offer a means to secure some new books. It is the hope of the Library Committee and the Board of Trustees, I know, that additional funds be made available in the future to allow for the purchase of the newest texts and reference studies available.

All these projects added to our annual operational expenses will continue to leave us little for a reserve fund. But as a non-profit organization our purpose is service to our membership, and to the public, and the responsibility is one for every Fellow of the Society.

Our books are in order for the year 1946, and a statement of finances is submitted herewith.

CHARLES J. ASHWORTH, M.D.
Treasurer

May 7, 1947

Summary

Total Cash Income (all sources)	$35,167.19
Total Expenses	29,100.62
Cash Balance	$ 6,066.57

* * * * *

General Fund (January 1, 1947) Cash	$ 6,066.57
Treasury Bonds	2,000.00
Total	$ 8,066.57

* * * * *

Receipts

Cash balance, January 1, 1946	$ 6,807.01	
		$ 6,807.01
Annual dues	$13,882.62	
Interest from Investments	796.30	
Payments, 1946 annual meeting exibits	652.50	
Payments, 1947 annual meeting exhibits	1,050.00	
Payments, 1946 annual meeting, dinners	1,120.00	
Payments, Members of Council for dinners at Council Meetings	120.00	
Providence Medical Association	4,069.09	
Miscellaneous (donations, reimbursements, etc.)	258.34	
		$21,948.85
Transfer of funds to General Account:		
Charles F. Gormly Fund	$ 102.51	
Endowment Fund	4,638.80*	
Participation Account	670.02	
Rhode Island Medical Journal	3,000.00	
		$ 8,411.33*
TOTAL		$37,167.19*

*$2,000 in U. S. Treasury Securities, Series G

Expenses

Annual Meeting (including dinner payments)	$ 2,337.42
Books	181.41
Committee expenses	283.82
Donations and dues	200.00
Electricity	43.36
Fuel	775.86
Gas	38.96
Insurance (Fire, liability, property damage, annuity)	1,744.72
Internal Revenue (withholding taxes)	1,223.96
Legal exenses	150.00
Library expenses, miscellaneous	433.64
Miscellaneous expenses, Society and executive office	398.11
Office supplies and equipment	258.91
Printing and postage	424.79
Refunds on dues to physician-veterans	404.20
Repairs to Library Building	4,626.68
Salaries	13,390.28
Sidewalk replaced	762.00
Telephone	215.87
Travel (officers and delegates to AMA)	1,206.63
Total	$29,100.62

continued on page 546

TYROTHRICIN

SHARP & DOHME

Concentrate

excellent topical antibiotic!

"For topical application . . . Tyrothricin is an excellent agent . . ."*

TYROTHRICIN is rapidly bactericidal—even in high dilutions—and exerts prolonged contact at the site of application. Low surface tension permits penetration of TYROTHRICIN into minute tissue crevices. This remarkably effective antibiotic is relatively stable and possesses low toxicity when applied topically. TYROTHRICIN is applied by instillation, irrigation, wet dressing or spray in treatment of gram-positive localized infections.

Indications: Superficial indolent ulcers, abscesses of the skin and soft tissues, chronic purulent otitis media, mastoiditis, sinusitis, empyema, certain types of wound infections.

TYROTHRICIN CONCENTRATE (*For Human Use*), Sharp & Dohme, is supplied as follows: (1) Package containing 1-cc. ampul of a concentrated solution of TYROTHRICIN, 25 mg. per cc., and a vial containing 49 cc. of sterile, distilled water for diluting the concentrate before use; and, (2) 10-cc. and 20-cc. vials of TYROTHRICIN CONCENTRATE, 25 mg. per cc. Sharp & Dohme, Philadelphia 1, Pa.

*Int. Abst. of Surg. 83:1-12 July 1946

TREASURER'S REPORT

continued from page 544

SPECIAL FUNDS

J. W. C. ELY FUND

A memorial fund established in 1912 by the son and the granddaughter of Dr. J. W. C. Ely, in the amount of $1500, to be called the J. W. C. Ely Fund and the income from which was to be used for periodicals.

52 shares, R. I. Public Service Company	$1,587.30
Interest	104.00
	$1,691.30
Paid to R. I. Medical Society for periodicals	104.00
Balance	$1,587.30

* * * * *

ENDOWMENT FUND

Started in 1912 when the Trustees (of the Fiske Fund) announced that they had voted to take the remuneration allowed them by the will, i.e., 2/12 of the annual income, amounting that year to $69.69, and to present this sum to the Rhode Island Medical Library to be the foundation of a "maintenance fund" for the support of the Library Building.

16 shares, National Bank of Commerce	$1,200.00
Interest	48.00*
74 shares, Providence Gas Company	906.50
Interest	48.10*
Peoples Savings Bank	2,599.16*
Interest	39.01*
U. S. Treasury Securities, Series G.	2,000.00**
Interest	25.00*
Total	$6,865.77

*Paid to Rhode Island Medical Society for building repairs	$2,759.27
**Transferred to General funds to compensate for expenditures for building repairs	2,000.00
	$2,106.50

* * * * *

E. M. HARRIS FUND

Established in 1921 by a donation of $5000 by Dr. E. M. Harris for "upkeep of the Library Building".

25 shares, Consolidated Edison Company	$2,346.88
Interest	125.00*
74 shares, Nicholson File Company	2,719.00
Interest	259.00*
Total	$5,449.88
*Paid to R. I. Medical Society for building repairs	384.00
Balance	$5,065.88

* * * * *

FRANK L. DAY FUND

Established in 1927 by a donation from the estate of Dr. F. L. Day, to be utilized for the purchase of books.

3000 Canadian National Railway Company	$2,979.75
Interest	202.50
Industrial Trust Company, checking account	693.62
Total	$3,875.87
Paid for medical books	111.53
Balance	$3,764.34

* * * * *

HERBERT TERRY FUND

Established in 1928 by a donation of $2000 from C. B. and C. H. Kenyon, in memory of Dr. Herbert Terry, for the purchase of books and periodicals and for the binding of same for the Library.

96 shares, Providence Gas	$1,152.00
Interest	62.40*
Total	$1,214.40
*Paid to R. I. Medical Society for books	62.40
Balance	$1,152.00

* * * * *

JAMES R. MORGAN FUND

Established by a donation of $500 in 1929 to be used for current expenses.

43 shares, Providence Gas Company	$ 526.75
Interest	27.95*
Total	$ 554.70
*Paid to R. I. Medical Socity for current expenses	27.95
Balance	$ 526.75

* * * * *

continued on page 548

Are these YOUR patients ?



The man who must be careful of his diet... yet requires plenty of rich, wholesome milk?



The youngster who demands lots of calcium and phosphorus for the building of sound bones and teeth?



The under-weight teen-ager, who lacks "pep"...who needs a pleasant yet dependable source of carbohydrates, proteins, fats and vitamins for energy and proper growth?

Then you'll be interested in these facts on Hood's Homogenized Milk.

In homogenized milk the cream globules are broken up into tiny particles (1/200th their original size) and distributed evenly throughout the entire bottle.

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H.P. HOOD & SONS

DAIRY PRODUCTS SINCE 1846

TREASURER'S REPORT

concluded from page 546

JAMES H. DAVENPORT FUND

Established in 1930 by a donation of $1000 for the purchase of books for the Davenport Collection of non-medical books written by physicians.

89 shares, Providence Gas Company	$1,068.00
Interest	57.85*
	$1,125.85
*Paid to R. I. Medical Society for books	57.85
Balance	$1,068.00

* * * * *

CATALOGUING FUND

It was voted by the Council, in 1932, to transfer the amount left from the Clinical Conference Fund to a fund for cataloguing the Library. This, together, with gifts, was deposited to establish the fund in 1933.

Providence National Bank $20.92
(Transferred to General Fund of Rhode Island Medical Society)

* * * * *

PARTICIPATION ACCOUNT

Providence Institution for Savings $670.02
(Transferred to General Fund of Rhode Island Medical Society)

COMMITTEE ON INDUSTRIAL HEALTH

The Committee on Industrial Health was active throughout the year and conducted four important meetings to discuss problems relating to industrial health in Rhode Island.

The Committee has approved of mass x-rays of industrial employees, and it has also noted the progress made by the Medical Society of the County of New York in establishing medical supervision of all industry within its limits. The Committee hopes that similar action may be initiated in Rhode Island, and recommends that the Rhode Island Medical Society study and adopt a program similar to that of New York.

The Committee has conducted a case investigation of reports printed in the daily press relative to the medical phase of the Workmen's Compensation Act in this State. The Committee has found that the reports were not accurate statements of fact as regards the participation of the medical profession in the program. At the same time the

continued on page 550



In All Anemias
Amenable to Iron Therapy

FERROUS GLUCONATE Breon
offers Iron Stabilized in Ferrous form

Radioactive iron experiments indicate that iron recently administered may be used for hemoglobin synthesis in preference to iron already stored.

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DRUGS

REXALL FOR RELIABILITY

In medieval times, the dragon was the symbol of the chemist and apothecary. Ancient alchemists were said to use dragon's blood in their potions, and the dragon came to mean certain chemical actions. An apothecary advertised his wares to the world by painting a dragon on a drug pot, and hanging it over his door.

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PHARMACEUTICAL CHEMISTS FOR MORE THAN 44 YEARS

COMMITTEE ON INDUSTRIAL HEALTH

continued from page 548

Committee is cognizant of the fact that the workmen's compensation plan in Rhode Island may be improved in many of its phases, and it urges that the Society take an active part in making such improvements.

The Committee specifically recommends to the House of Delegates that it authorize the Committee on Industrial Health to draft a suggested fee schedule for workmen's compensation benefits and that such schedule be submitted to the Society for approval before being made public.

The Committee also recommends that the House of Delegates place itself on record as being willing and anxious to check any abuses of the medical phase of the Workmen's Compensation Act in Rhode Island, and that it authorize the Committee on Industrial Health, in particular, to continue to participate with State and private agencies in the improvement of the Act.

The Committee has noted with great interest the expansion of industrial health activities, and it urges the membership of the Committee on Industrial Health be retained in office for longer than a one-year term in order that a successful long-range policy may be developed. In this connection the Committee recommends to the House of Delegates that there be closer cooperation between the Council of the State Society and the Chairman of the Committee annually relative to the nomination of members of the Society to serve on the Committee on Industrial Health.

COMMITTEE ON INDUSTRIAL HEALTH

Stanley Sprague, M.D., *Chairman*
James P. Deery, M.D.
Arthur E. Martin, M.D.
George Conde, M.D.
Richard F. McCoart, M.D.
Daniel Troppoli, M.D.
Edward Medoff, M.D.
Charles L. Farrell, M.D.
Thomas A. Egan, M.D.

COMMITTEE ON POST GRADUATE EDUCATION

This Committee has not been active because no demand for organized post-graduate teaching has developed in the membership of the Society other than that which is being carried on by the various hospitals.

Speakers and subjects for those district societies which requested them have been furnished by the office of the Executive Secretary from the lists prepared by the Committee. The opportunity to be of

continued on page 552



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Some things you would like your patients to know **about Epilepsy**

The educational message on Epilepsy, shown below, will appear in full color in LIFE and other national magazines . . . reaching an audience of more than 22 million people. This is No. 205 in the "See Your Doctor" series, published by Parke-Davis in behalf of the medical profession.

Some things you should know about epilepsy

No. 205 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.

EPILEPSY is one of the most widely misunderstood of all diseases.

Many people believe that there's no effective treatment for it, that it's a kind of feeble-mindedness, that it always becomes worse as the patient grows older, and that he has no chance of leading a normal life.

Your doctor, however, will tell you these ideas are false.

The truth is that medical science has accomplished a great deal in its attempt to control epilepsy, and today the outlook for most persons who have the disease is distinctly hopeful.



What is epilepsy?

In broad and simple terms, epilepsy is a disorder in which the patient suffers recurrent nervous seizures. These seizures—usually characterized by muscular convulsions and sometimes by the loss of consciousness—vary greatly in frequency, duration, and intensity.

The fundamental cause of epilepsy is unknown, although a variety of contributing causes have been established.

Contrary to popular belief, heredity as a rule does *not* play the major role in epilepsy. The chances that an epileptic will have an epileptic child are only about one in forty.

Can epilepsy be controlled?

Epilepsy most often begins in childhood or adolescence. In times gone by, a diagnosis of epilepsy was a dreadfully heavy blow. But today the doctor can usually give the parents—and the child—much encouragement and hope. The following figures explain why this is so:

In approximately one out of six cases, the disease eventually disappears—and disappears completely.

Where the disease does not disappear, nearly 50 per cent of the patients are—with proper medical care—entirely free of seizures. Another 25 per cent or so can be almost entirely free, and can lead a virtually normal life.

The treatment of epilepsy

In most cases, modern drugs are the doctor's chief weapon. *Only the doctor knows which drug or drugs should be used, and in what dosage.*

Using these medicines, the doctor has been able to give epileptics a new lease on life. Once haunted by the threat of seizures and the danger of gradual mental deterioration, they often spent their days in tragic seclusion. But now most of them can lead normal lives. They can work, swim, dance, and play golf or other games. Children can go to regular schools and are able to study and play on a par with their schoolmates.

SEE YOUR DOCTOR! If you or your children ever experience a seizure—however mild—*see your physician promptly.* With epilepsy, as with any other disease, he can be of greatest help when you give him a chance to fight the ailment in its *earliest* stage.

Makers of medicines prescribed by physicians

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COMMITTEE ON POSTGRADUATE EDUCATION

continued from page 550

service in helping organize the program of the new Veterans Hospital which it was hoped would be given to this Committee has not developed. It is expected that, now that so many physicians have returned from the armed forces and become re-established in practice, a demand for post graduate instruction may develop. It is also anticipated that during the coming year the new Veterans Hospital staff may be organized.

It appears probable, therefore, that in the year ahead, ample opportunities will be presented for this Committee to be of service.

B. Earl Clarke, M.D.
Frank Cutts, M.D.
George Alexander, M.D.
Fred Riley, M.D.
Henry Moor, M.D.
Francis King, M.D.
Elihu S. Wing, M.D.
Meyer Saklad, M.D.
Alex M. Burgess, M.D., *Chairman*

COMMITTEE ON THE LIBRARY

The year 1946-1947 has been, in some respects, the busiest in the history of the Library. We have had a total of 1930 visitors; 1749 during the day and 181 during evening hours. This figure is not as high as it has been for some of the years before the war but the volume of reference work has been larger than that of any previous year. Many of the subjects have involved hours or even days of painstaking research.

The circulation of books and journals has increased, also. Nine hundred and fourteen journals and 191 books have been charged out and returned during this period; 148 journals and 36 books are out at the present time.

We have added 169 books through purchase, gift and review. Of those purchased, 24 were for the main library, 7 for the Gormly Collection and 6 for the Davenport Collection. The Library is receiving 166 journals through subscription and exchange.

Gifts of books, journals and pamhplets were received from the following: Doctors Abbott, Adams, Beck, Corrigan, Morgan Cutts, DeWolf, Hammond, Kramer, Lagerquist, Mowry, Putnam, Clara and Joseph Smith and Welch, and from the Providence Lying-In Hospital, Providence Public Library, Brown University, Aurex Corporation, Eli Lilly Company, Ethicon Suture Laboratories, Mead Johnson Company, Nutrition Research Laboratories and the National Foundation for Infantile Paralysis, Inc.

Eighty-five volumes of journals were bound

continued on next page

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this year; 6 were repaired. There are 46 volumes at the bindery now.

We have borrowed books from other libraries, through inter-library loan, 8 times and have loaned books 47 times.

The Library shipped 3 large cartons of duplicate journals to the American Book Center in Washington, D. C. This material will be used in the work of restoring the war devastated medical libraries of Europe.

We are arranging, through Doctor Wilson of the Biology Department of Brown University, to loan our partial run of Virchow's Archiv to the University where it will be used to help complete their file. Our volumes, however, will remain the property of the Rhode Island Medical Society and will be available to our members on the same terms as they would be if on our own shelves.

The Library owns 34,402 volumes that have been counted. However, those shelved on the third floor have not been counted for many years and we estimate that our present holdings must be very close to 38,000 volumes. Of these, 23,243 have been catalogued.

Respectfully submitted,

Russell S. Bray, M.D., *Chairman*
Herbert G. Partridge, M.D.
Herbert E. Harris, M.D.
Robert T. Henry, M.D.
Paul Appleton, M.D.
G. Raymond Fox, M.D.
Paul C. Cook, M.D.
Amy E. Russell, M.D.
Clarence E. Bird, M.D.

PAWTUCKET MEDICAL ASSOCIATION

A regular monthly meeting of the Pawtucket Medical Association was held Thursday evening, May 22, 1947, at 9:00 p.m. in the Nurses' Auditorium of the Memorial Hospital, Pawtucket.

The meeting was called to order by the President, Earl J. Mara, and the minutes of the previous meeting were accepted as read by the Secretary.

Dr. Shavarsh Harry Markarian and Dr. Robert Jerome DuWors were unanimously elected to membership in the Association after the Secretary reported that their applications had been approved by the Standing Committee.

Dr. Mara asked for suggestions regarding the Woman's Auxiliary for the Pawtucket District and said that there would be more information about this matter at a later date.

Dr. Joseph Doll moved that the by-laws of the Association regarding the present required membership in the State Medical Society be suspended. This motion was put to vote and was defeated only by the negative vote of the chair.

Dr. Charles Farrell gave a brief report from the House of Delegates and also from the Board of Editors of the RHODE ISLAND MEDICAL JOURNAL.

Dr. Mara then introduced the speaker of the evening, Dr. Frank A. Merlino, Clinical Director of the State Division of Tuberculosis Control, who discussed and presented some interesting films on Mass Chest Photofluorography Surveys.

Refreshments were served and the meeting adjourned at 10:00 p.m.

Respectfully submitted,

KIERAN W. HENNESSEY, M.D.
Secretary

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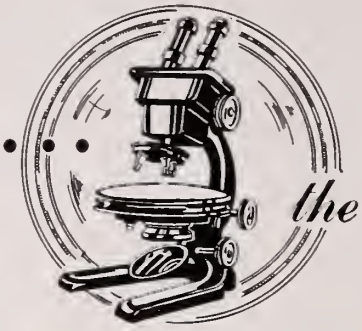
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A M A Centennial

There was little doubt in the mind of anyone who attended the annual AMA sessions that the centennial meeting was the biggest, best, and probably the busiest ever held. And since the seashore held little attraction for a New Englander who thinks that the Narragansett shore line tops them all, the convention afforded a busy four days of activity indoors for this observer.

Conference of State Presidents and Other Officers

It was a real sacrifice to relinquish the sunny boardwalk on Sunday afternoon for the confines of the Ritz Carlton to attend the first allied meeting of the convention — the Conference of Presidents and Other Officers of State Medical Societies, an organization Dr. Elihu S. Wing and your observer aided in forming at Detroit some three years back. But the afternoon was well spent, for the talks by the three Cincinnatans — Dr. Schriver, president of the Conference, Dr. Hawley, medical administrator of the VA, and Senator Taft — provided some ideas that provoked much after-discussion by the delegates and other officers.

With the VA program a subject of contention in many parts of the country the remarks of Dr. Hawley drew careful attention. Your observer's notes, hurriedly jotted down, include the following highlights of this talk: That the experience in the VA hospitals where private physicians have served on a part time basis has proved the contention (made by Dr. Schriver in his address) that the veteran will never get the best medical care until the private physician renders it . . . That in the past 12 months more mental discharges have been effected than there have been admissions for mental problems . . . That the VA is required to provide out-patient service and there appear to be two ways to do it, (1) by providing clinics, or (2) by abolishing all existing VA clinics and having the work done by general practitioners . . . But it is impossible to provide clinics, as that would necessitate one in almost every county; and while the abolishing of the clinics in favor of care by private physicians has merit, its disadvantages include the failure of the general practitioner to make the pension claim examination as well as the clinic (due to reporting of findings, etc., and *not* due to zeal or ability of the physician), and the problem of providing prosthetic appliances . . . Then, too, claims are settled by a lay board and hence trained VA medical personnel are necessary to present clearly the case . . .

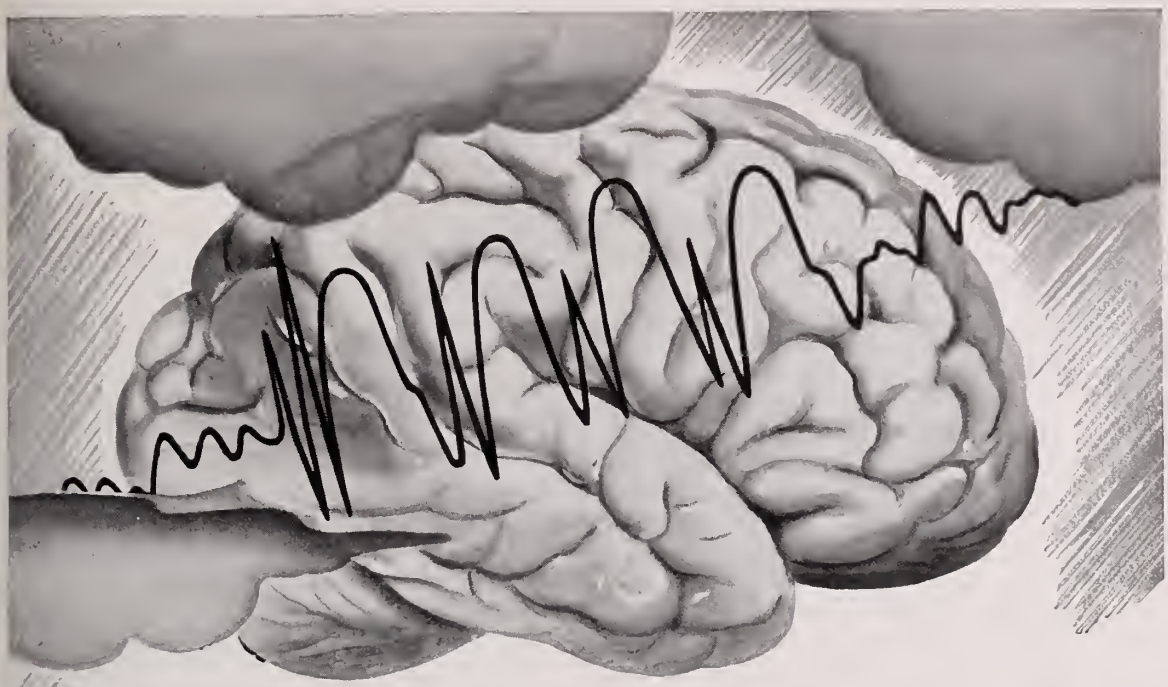
The problem, according to Dr. Hawley, might be adjusted by (1) limiting the number of clinics, and (2) using the general practitioner as much as possible. In the main, he pointed out, the present situation is subject to adjustments arising from (1) misunderstandings, (2) both active and passive resistance by the 'old guard' in the VA who do not favor the new program, and (3) sheer stupidy.

Considering the fee question, Dr. Hawley pointed out that he felt that the fee schedule with societies should be negotiated on the basis of (1) adequate fee for the physician to give the veteran the complete security of a private patient, and (2) protection against overcharges . . . The great majority of the profession has been most fair to the veteran and the VA, but a small percentage of doctors can give a "bad name" to the profession . . . Agreements in 38 states now result in the payment of approximately 32 million dollars a year to private practitioners, an average of $213 per year per physician on a 48 state basis.

Taft Discusses National Health Legislation

Speaking forcefully, and with an apparent sincerity, Senator Robert Taft brought to the Conference a better understanding of the health issue at the national legislative level. After reviewing the development of such acts as the Hill-Burton hospital construction measure; the Scientific Foundation act to provide

continued on page 556



BRAIN STORM

The encephalographic tracing of a typical epileptic seizure with its large widely spaced waves resembles a gale-swept sea. By calming the cortical storm without producing noticeable drowsiness, Mebaral makes the lot of the epileptic much more tolerable. The average dose for adults is from 3 to 6 grains daily; for children from 1/2 to 3 grains daily. Tablets 0.03 Gm. (1/2 grain), 0.1 Gm. (1 1/2 grains) and 0.2 Gm. (3 grains).

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THROUGH THE MICROSCOPE

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for a study relative to the distribution of funds for research, including cancer and heart disease; and the Pollution Abatement measure (in which Rhode Island has a vital stake) estimated to cost three billion dollars, he pointed out that domestic plans must necessarily be held up until the tremendous appropriations for war expenditures subside — possibly in another year.

Discussing national health legislation placed before Congress, Senator Taft drew sharp attention to the conflict in the American philosophy with reliance on a free system opposed by complete operation of the entire economy by government. Citing that the free system, augmented by a supplemental charitable system, has built a great health record for this country, he proceeded to a criticism of the Murray-Wagner Dingell compulsory legislation.

Similar to previous legislation by the same proponents, the new act, according to Senator Taft, implies payment of a 4% tax, but does not levy the tax or tell how it will be paid. This method of writing the measure was done in order to keep it out of the Finance Committee which would necessarily be primarily concerned with costs of operation which would ultimately effect the entire economic pattern of the country. Citing that 4% of a $3,600 income is twice as much as the Michigan and California medical service plans now charge for their voluntary insurance programs, Senator Taft drew attention again to the fact that the M-W-D act is NOT insurance, but a tax plan.

Stating that some states are faced with great difficulty now in raising funds on the local tax level for essential services such as schools, roads, etc., and that the federal government is raising 40 billion dollars, and the States another 10 billion, Senator Taft maintained that further increases at the state level will result in the loss of productive businesses. (And your observer was mindful of the recent Assembly and public discussion in Rhode Island on the state budget which has resulted in a new sales tax to meet what are now current state government expenses).

Health, according to the Senator, has generally been at the tag end of the budget, with the result that the poorer states are not coming anywhere near meeting public aid needs. Hence, he advanced strong arguments for his Taft act, now before Congress, which would give assistance to the 20% of the people who need it, and not force it on 95% as proposed by the Murray-Wagner-Dingell-McGrath measure.

Under his act, Senator Taft proposes a fund of 200 million dollars to be given the States to aid any state to set up a plan to provide medical care for all who cannot purchase it. The plan involves a means test; but, he pointed out, every hospital and every physician now has to apply some means test in rendering services. Also, public housing is predicated on a means test. Hence this objection has little merit in fact.

Citing that his act (S. 545) does not control the medical profession, he posed the question to the Conference as to whether we want to improve the present free system, or abolish it for a government-controlled system.

House of Delegates Meeting

On the Monday the House of Delegates assembled for what turned out to be a very busy week of activity. The early sessions saw the introduction of delegates representing the various nations of the world who extended special greetings to the AMA on its 100th birthday. Then came the serious round of reports of committees, resolutions, and discussions.

Of particular interest to Rhode Island was the supplementary report of the Council on Medical Service which included a preliminary statement of a study of cash sickness compensation programs and promised a detailed study later. (In July, 1946, the R. I. House of Delegates submitted a resolution requesting that the proper council or agency of the AMA make a study of the medical phases of cash sickness compensation plans and report by the first of this year.) Another item of interest in the report from this Council was the request that it be authorized to meet with the Veterans Administration and endeavor to effect a more satisfactory agreement relative to care of veterans through cooperative efforts of state medical societies. These, and the many other reports and resolutions (some interesting ones relative to the general practice of medicine, hospital specialty boards, etc.) have been or will be published in the Journal of the AMA, and warrant reading by all members.

Surgical Study Committee Holds Meetings

During the convention week members of the surgical study committee of the Rhode Island Medical Society, headed by chairman Dr. Rocco Abbate, met with representatives of other states that are interested in the development of the voluntary surgical plan through private insurance companies. A meeting was also held with representatives of the Council on medical Service of the AMA which recognizes the Rhode Island approach as one of the best advanced to date, and as superior in many respects to the Wisconsin Plan, the forerunner in this method of extending prepaid surgical and medical care under state medical society sponsorship. It is of in-

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The uses of Fiberglas* materials described in this edition are:

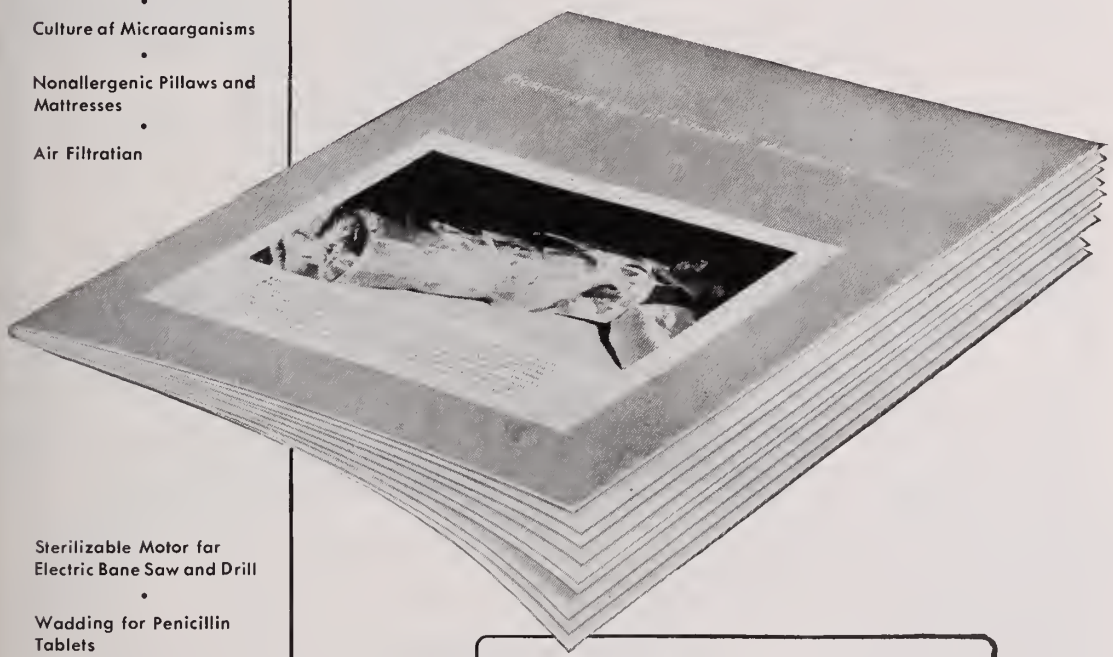
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THROUGH THE MICROSCOPE

continued from page 556

terest to note that the Arkansas State Medical Society has given the John Marshall Insurance Company of Chicago, a private stock company, its exclusive endorsement to merchandise a low cost medical-surgical-hospital program to the two million residents of that state; Illinois is studying such a program, as is Tennessee and Minnesota, to name a few of the leaders in the field. Of greatest interest to all was the fact that Rhode Island has been able to bring some of the major insurance companies of the country into its program.

At the Exhibit Hall It was not until Wednesday morning that your observer took time to visit the convention hall to see the exhibits. And see is the right word, for it would require the time of several days actually to travel the entire hall, stopping and studying the hundreds of technical and scientific displays. Naturally we made a stop at the scientific exhibit presented by Drs. Meyer and Elihu Saklad, and Priscilla Sellman, only to find such a group of interested physicians listening to Dr. Sellman explain the technique presented that we never did get to the front row to make our presence known.

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We were to meet Dr. Batchelder "under the clock", but that spot proved one of the most popular with free "cokes" being dispensed at one booth, and cigarette cases at an adjoining one. The result: Dr. Batchelder and your observer never did meet to check some of the exhibits that we might seek for showing at Providence next year for the Providence Medical Association Centennial. But your observer did learn a few facts previously not known to him, that (1) the 1847 registration book of the AMA for its first meeting carried the names of two Rhode Island delegates, Dr. Theophilus C. Dunn (whose name we never recalled) and Dr. Usher Parson of whom we have read much relative to his exploits as the only surgeon with Oliver Hazard Perry's fleet at the battle on Lake Erie; and (2) that Rhode Island was the tenth state medical group to officially organize (New Jersey was first, in 1766).

CENTENNIAL MEETING OF THE AMA

concluded from page 522

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CHARLES POTTER, M.D.

FUNDAMENTALS OF CLINICAL NEUROLOGY.

By: H. Houston Merritt, Professor of Clinical Neurology, College of Physicians and Surgeons, Columbia University; Fred A. Mettler, Associate Professor Anatomy, Columbia University; Tracy Jackson Putnam, Profesor of Neurology; Neurological Surgery, Columbia University. Pg. 261. The Blakiston Co., Philadelphia, Pennsylvania.

This book has worth. The fundamentals of clinical neurology are so well depicted. The combining of anatomy and pathology, to make the clinical picture have meaning, has been skillfully brought about. The authors are to be congratulated for blending so adeptly their special interests into a unified whole. For the general practitioner, the beginner in neurology, and the expert in neurology, this happy blending will be most useful and satisfying.

This book is successful in other ways. The exposition of the ideas is done clearly and in a most readable fashion. Sentences are short. Words are chosen for the primary purpose of getting over an idea. There is joy in merely reading the book. Exemplary of this point are the accounts of "The Babinski Phenomenon" and "Muscular Disorders Due to Myoneural Junction Dysfunction".

The extent of the index and the care with which it has been done adds materially to the value of this book.

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Volume XXX, No. 8

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WHENEVER NUTRIENT INTAKE MUST BE AUGMENTED

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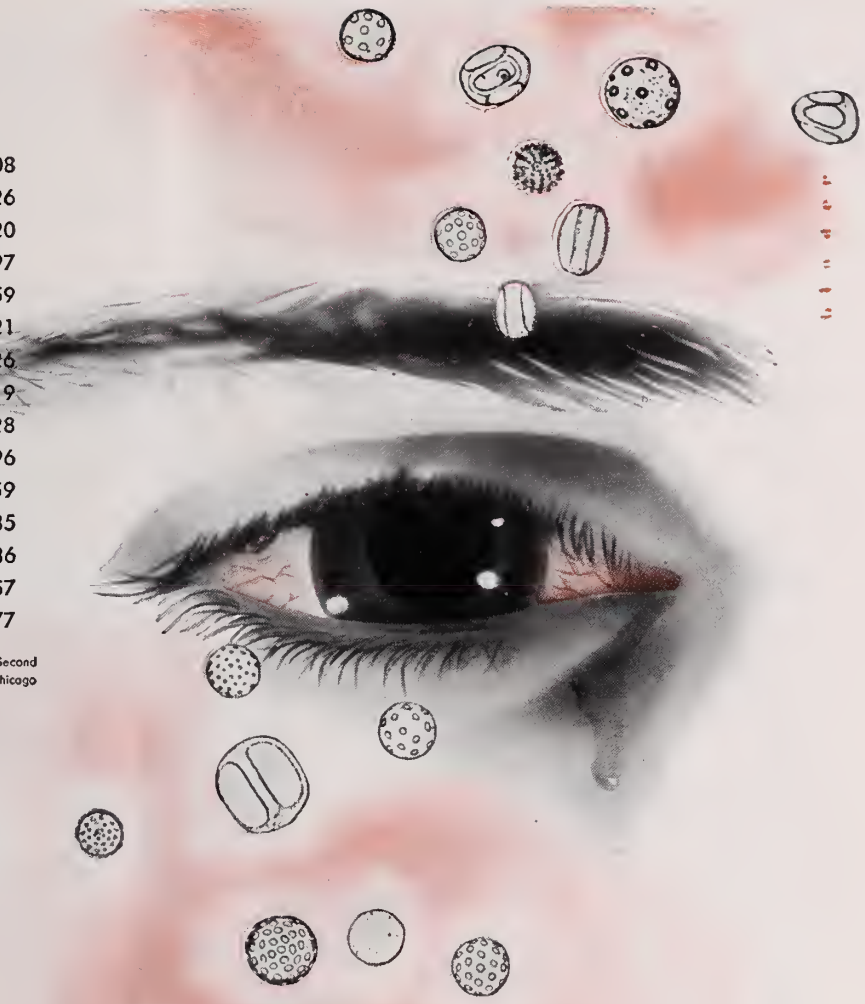
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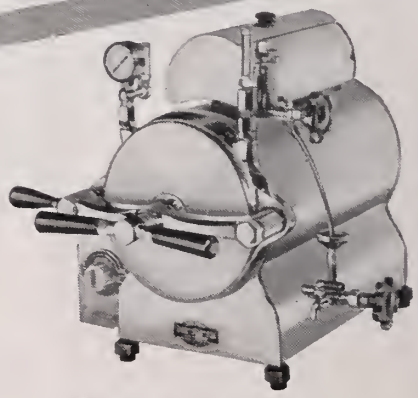
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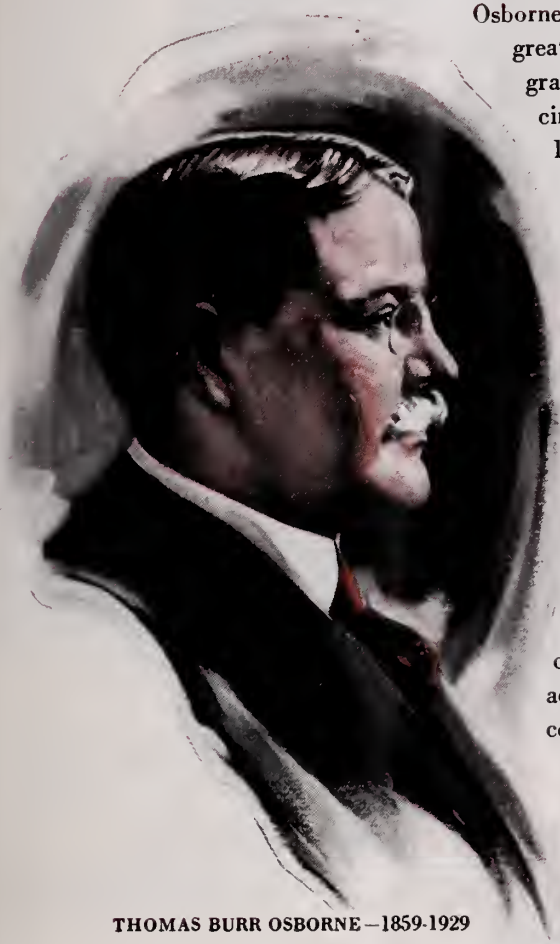
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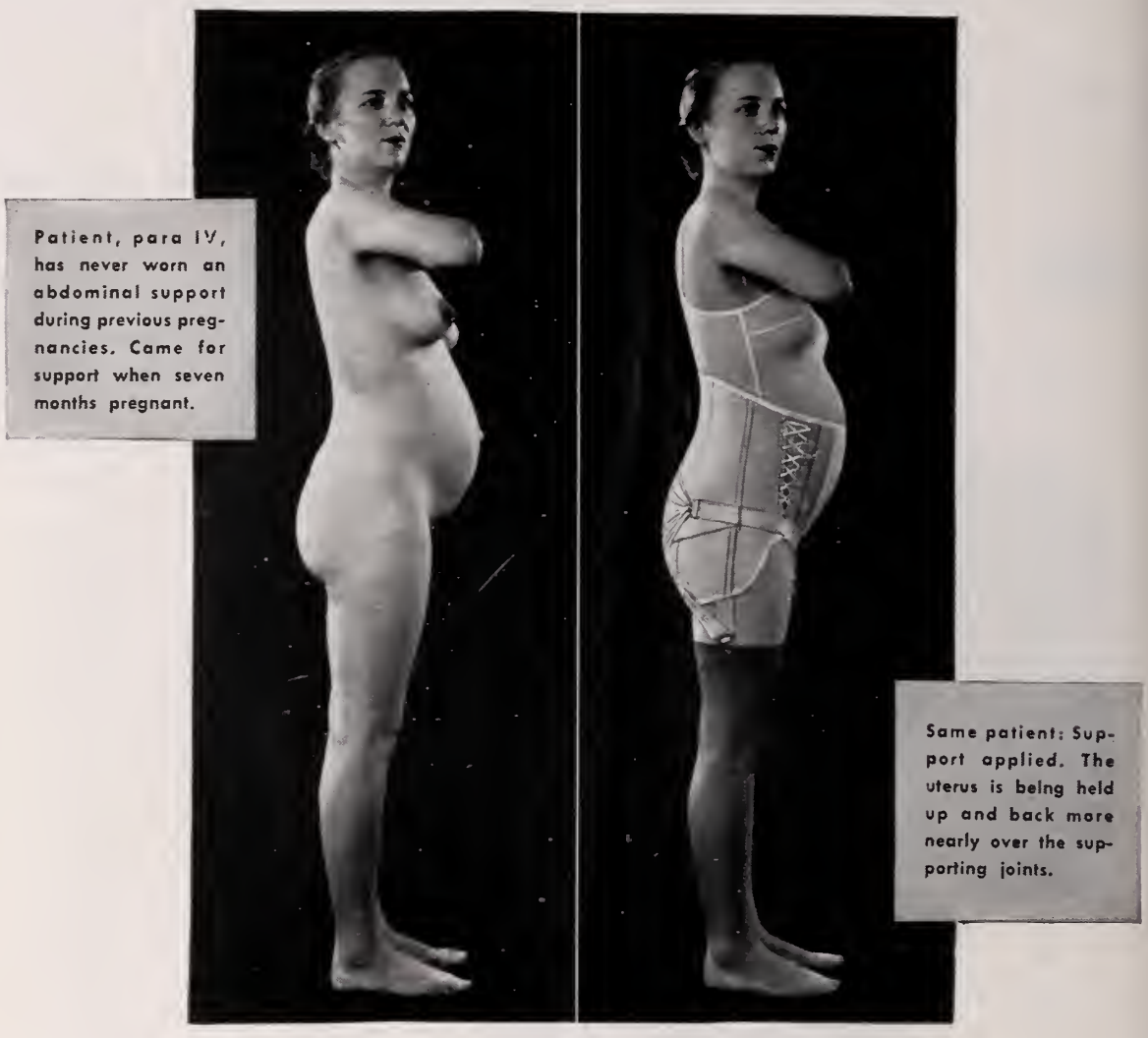
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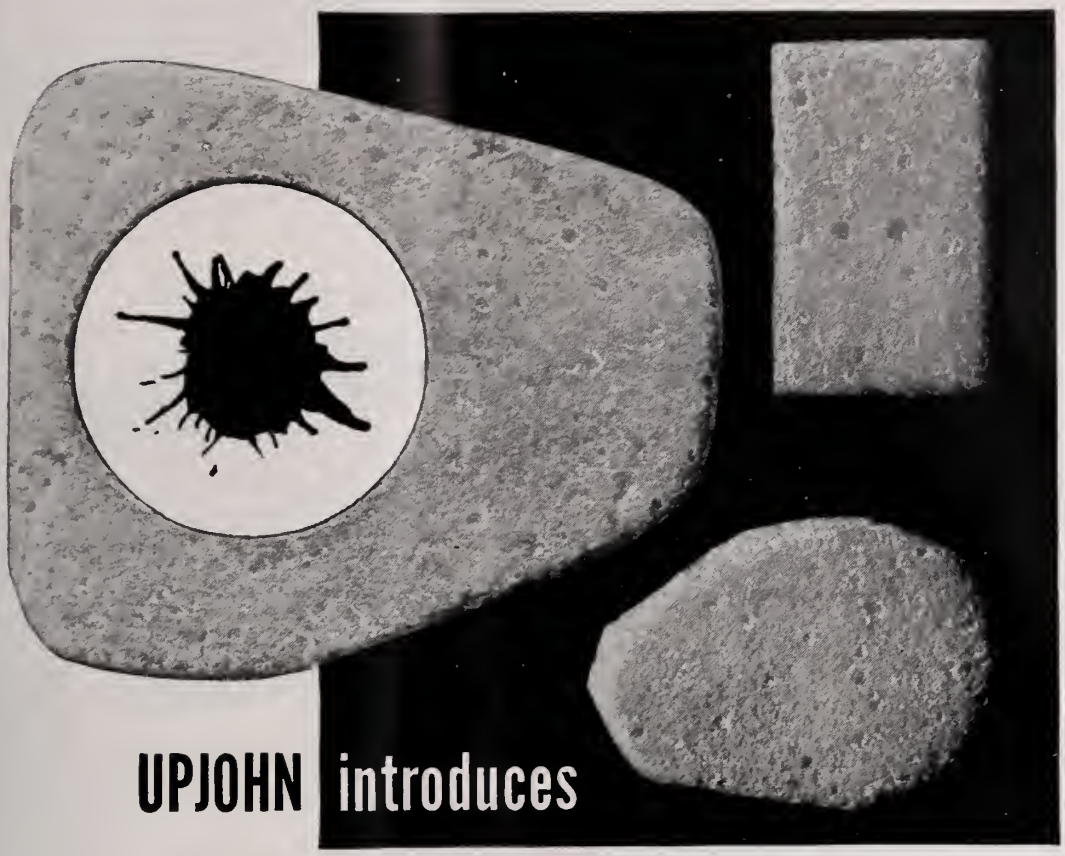
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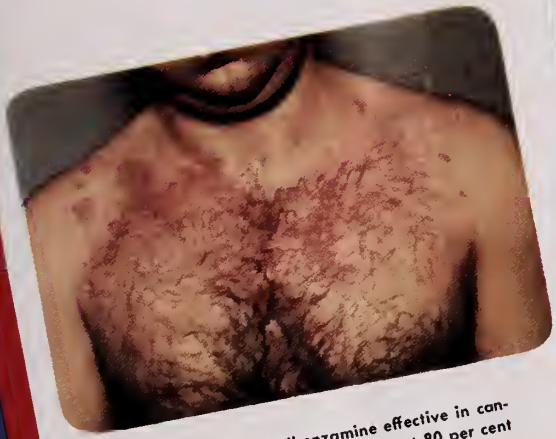
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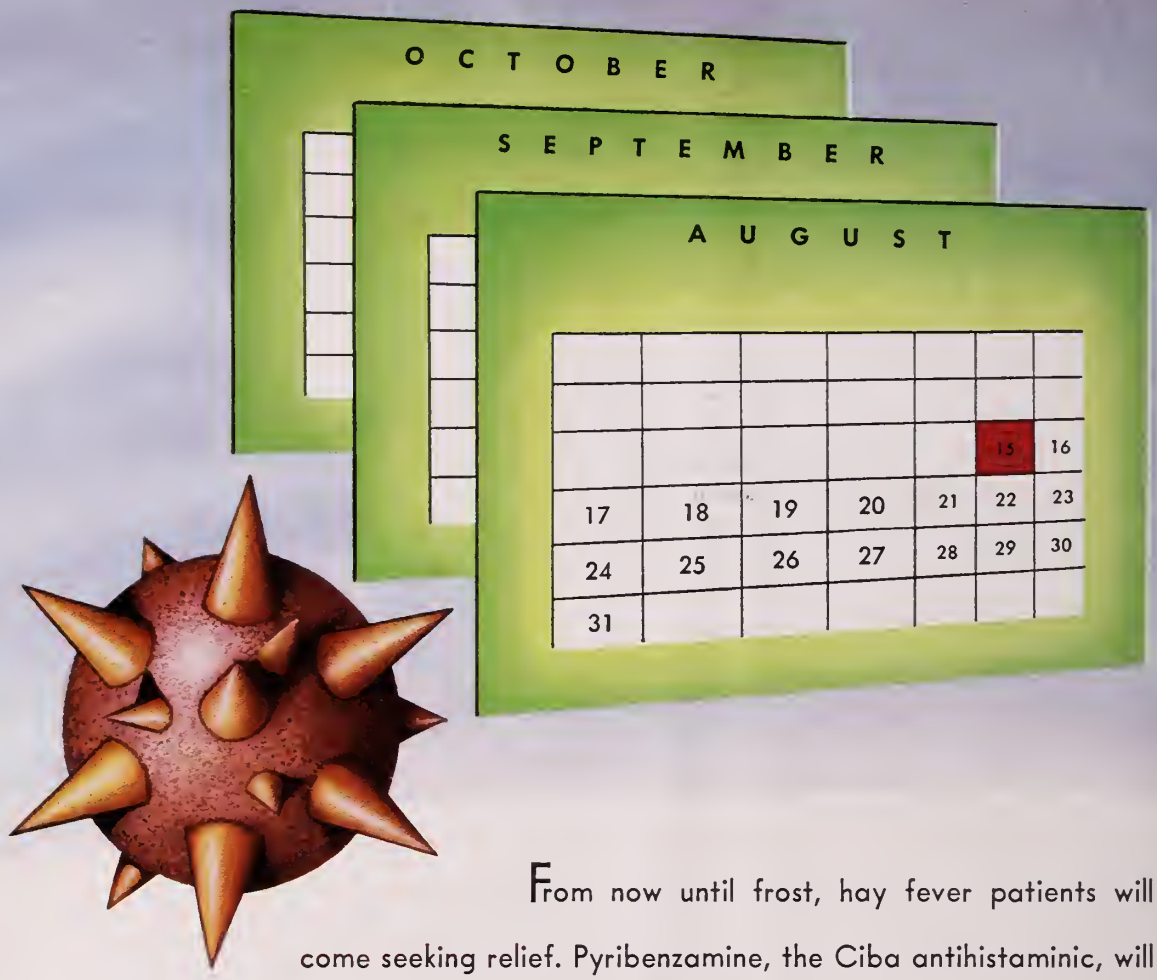
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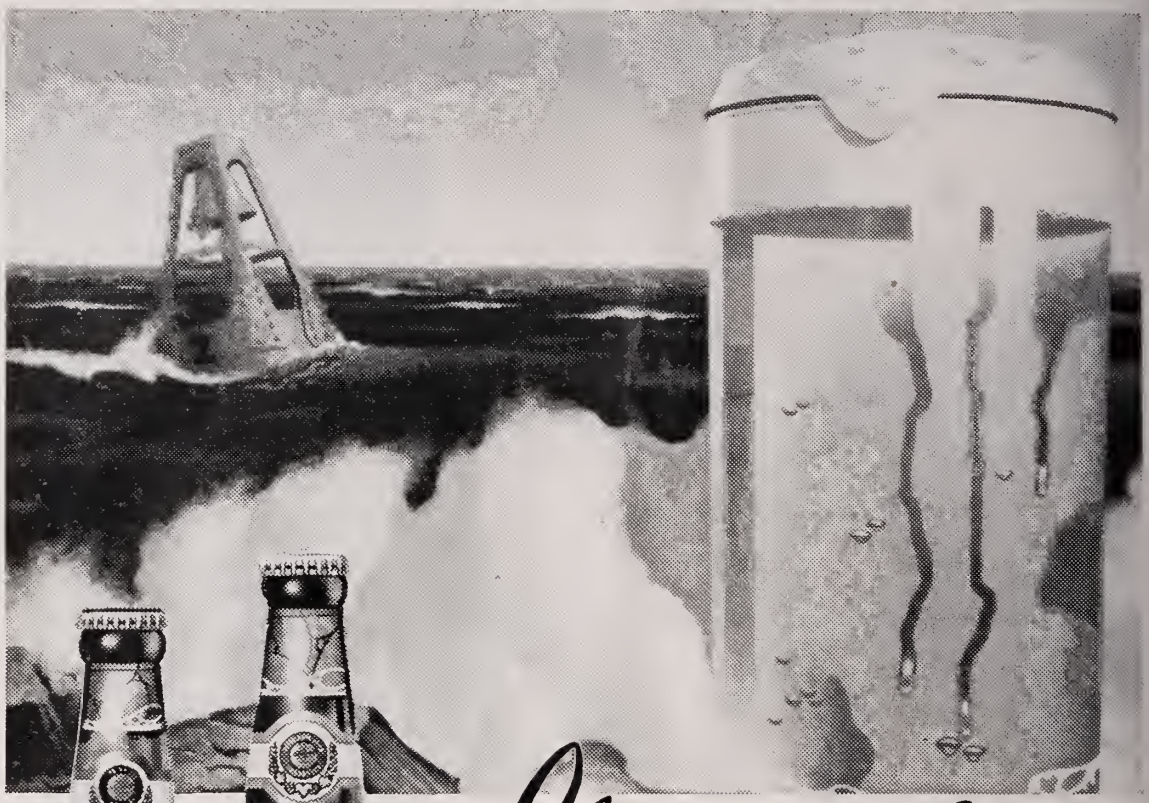
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AS EARLY as the fourth century B.C., Greek physicians suspected that marshy lands had some connection with malaria. It was not until 1894, however, that Sir Patrick Manson, English physician, advanced the hypothesis that malaria was transmitted by the mosquito. At Dr. Manson's suggestion, Sir Ronald Ross not only traced the development of the parasite in the mosquito but infected healthy birds with malaria. A riddle of many centuries was finally solved!

This epochal discovery indirectly led to the development of millions of acres of fertile bottom lands formerly considered unfit for healthful habitation. It then became a problem for the engineer to develop techniques of drainage and reclamation.

Removal of major breeding places for the mosquito, although important, is not the whole solution to the problem. Effective drugs are still needed. Research on new and more efficient antimalarial agents continues in the Lilly Research Laboratories.

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ANTI-BIOTIC AGENTS IN CLINICAL MEDICINE*

CHESTER KEEFER, M.D.

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MR. CHAIRMAN, Members of the Rhode Island Medical Society and Guests. In discussing anti-biotic agents in clinical medicine this afternoon, I shall confine my remarks to the use of penicillin and streptomycin.

I propose beginning my discussion with some remarks concerning the various dosage forms of penicillin that are available at the present time.

The most widely used preparation of penicillin has been amorphous penicillin, administered in aqueous solution. More recently, crystalline penicillin G, either the sodium or potassium salt, has been generally available. This preparation is most popular for the reason that it contains one of the most active penicillins, and it is the only penicillin available in crystalline form for clinical use.

There is no choice between the use of either the potassium or sodium salts of crystalline penicillin G, as they are both active biologically, and they are both stable, without refrigeration.

Another preparation that has had wide use is the one developed by Dr. Romansky and his associates, namely, penicillin in oil and beeswax. The purpose of this preparation is to delay the absorption of penicillin from local deposits in the muscles. The first preparation to be developed was amorphous calcium penicillin, in peanut oil and beeswax.

Crystalline penicillin G, suspended in oil and dispersed in wax, is now available for clinical use. It has been found that a single injection of one cubic centimeter of this preparation containing 300,000 units per c.c will provide assayable blood levels, in most patients, for a period of twenty-four hours. If 600,000 units are given in a single injection, it is found that in all patients there will be assayable blood levels throughout the twenty-four hours. Or, if one divides the total dose of 600,000 units daily in halves and gives 300,000 units every twelve hours, one can be certain that there will be assayable blood levels throughout the twenty-four hour period.

Oral preparations of penicillin have been widely used. These preparations have been limited somewhat by their excessive cost. It is known that it requires at least three to five times as much penicillin when it is administered by mouth, as when it is given parenterally, in order to obtain comparable clinical results or comparable blood levels.

It is well to say then that 300,000 units of penicillin a day in oil and wax will usually be adequate for the treatment of most infections. If two injections are given daily at 12 hourly intervals, then one can be certain that all patients will have assayable blood levels for a period of 24 hours.

In using oral penicillin, the one thing to remember is that at least three to five times as much penicillin should be used as is generally employed by the parenteral route.

With respect to dosage, there is no rule about dosage of penicillin in any given infection. The reason for this statement is that different organisms vary so widely in their sensitivity to the action of penicillin. When you consider that most patients with gonorrhea are cured within a period of fifteen hours, following the use of 100,000 to 150,000 units total dosage, and it often requires six to eight weeks using half a million units a day to cure patients with subacute bacterial endocar-

continued on next page

* Presented at the 136th Annual Meeting of the Rhode Island Medical Society, at Providence, May 14, 1947.

ditis, you can appreciate the wide range of dosage that is needed for the treatment of various infections.

The best rule to follow, once the type of infection is known, is to give that amount that will bring the infection under control in the shortage period of time.

One other subject that is often discussed is the question of bacterial resistance to penicillin. Fortunately, this is a problem that has not given us very much concern, for the reason that it plays little or no part in explaining penicillin failures. It is true that you can make micro-organisms more resistant by multiple dosages, but that plays very little role in clinical infections. There are some strains of hemolytic staphylococcus aureus that are resistant from the beginning, so that very large amounts of penicillin will not destroy the organisms. But, the development of acquired resistance has been of little or no importance in explaining penicillin failures.

The results of the use of penicillin in most infections are well known to you. But, to repeat, one can say that penicillin continues to be the drug of choice in all staphylococcal infections, in all pneumococcal infections, in hemolytic streptococcal infections, and in gonorrhea and syphilis the two most prevalent venereal diseases, and subacute bacterial endocarditis, due to non-hemolytic streptococcus.

Following the use of amorphous penicillin, the degree of hypersensitivity that develops in different patients varies between three and five per cent. That is to say, between three and five per cent of all patients who receive penicillin for a period of seven to ten days become sensitized to it, and develop urticaria.

There has been a general impression that the incidence of hypersensitivity is higher among those receiving peanut oil and beeswax. Statistical studies bear this out only in part. When alternate cases are studied with crystalline G in aqueous solution and crystalline penicillin G in peanut oil and beeswax the incidence of sensitivity was approximately three per cent for aqueous and five per cent for peanut oil in beeswax.

When peanut oil and beeswax are used, somewhat higher incidence of hypersensitivity may be observed.

The urticaria accompanying hypersensitivity is readily controlled in most instances by the use of benadryl or pyribenzamine. These drugs are of value in the treatment of the urticaria.

With respect to streptomycin, the only dosage forms that have been available are the chloride, the sulfate, and phosphate salts. Streptomycin has the characteristics of an organic base, and it can be combined with chloride or sulfate or phosphate. In our experience, there is no choice between the different salts. They are all equally effective. They are all equally soluble, and they are absorbed with the same rapidity from deposits in muscles.

The intramuscular route is the one of choice since very little streptomycin is absorbed from the gastrointestinal tract. It is absorbed in such small amounts that it would be of no practical use in the treatment of systemic infections.

The dosage schedules in streptomycin have varied, depending upon the type of infection. The smallest amounts have been found necessary in patients with tularemia. That is a disease of no great importance in New England, but in the United States there are approximately 20,000 cases a year, with a total fatality rate of seven per cent. In the pulmonary form, however, the fatality rate is as high as forty per cent. In this disease then, only one half or one gram a day, for five to seven days, proves to be adequate. Most patients with urinary tract infections will require from one to two grams daily for five to seven days. If the urine of the patient is not sterilized within a period of seventy-two hours, one is usually dealing with a resistant organism, or some complicating factor, such as a foreign body in the genito-urinary tract or an undrained abscess.

In patients who have tuberculosis, the usual dosage schedule has been much larger; namely, between two and three grams a day for a period varying between two and three months. The problem of the treatment of infections with streptomycin is somewhat different from that of penicillin, for the reason that most organisms that are susceptible to streptomycin have a much greater tendency to become resistant or to develop resistance during the course of exposure to streptomycin. In fact, Dr. C. Philip Miller has recently shown that at least one variant of the meningococcus requires streptomycin for its growth; with this variant streptomycin becomes an essential growth factor for the meningococcus. So far, no other bacterial species have been found in which streptomycin is required for the growth of the organism.

The problem of increased resistance of gram negative bacilli to streptomycin is a very real one, and explains, in many instances, streptomycin failures.

Another stumbling block in the use of streptomycin has been the side effects that have occurred following its use for periods longer than seven to ten days. You will find that a certain number of patients develop hypersensitivity reactions, urticaria, fever, etc., and they are not very serious, in that they do not produce any permanent damage or destruction of tissues. The most serious side effect, of course, has been the vertigo that occurs in varying frequency, depending upon the time-

dose relationship. In most patients who receive streptomycin for periods varying between two and three months, in amounts of one 1½ to 3 grams a day, vertigo will develop between the seventeenth and the thirtieth day. This comes on suddenly, is often very disturbing to the patients, and is very severe.

In general, most of these patients learn to compensate for the vertigo, so that after a period of thirty, sixty or ninety days, all symptoms and signs of vertigo may disappear, and no damage can be detected, unless tests for labrynthine function are carried out. In many instances, however, the decrease in this function has persisted for as long as a year, or for as long as many of the patients have been followed. If you give streptomycin for a long period of time, that is, for over a month, to patients with tuberculosis, for instance, you can expect to find that most of the individuals will develop vertigo. If it is given for a period of five to seven or ten days, then only about five per cent of the patients will develop vertigo.

Deafness has been reported under three circumstances,—in patients with meningitis, who received large amounts of streptomycin intrathecally, and in those who received excessively large amounts of streptomycin systemically six to ten grams a day, with the expectation that the disseminated tuberculosis might be brought under control.

Finally, there is a group of patients who have received relatively large amounts of streptomycin, in the presence of renal insufficiency, who have become deaf.

Deafness may be observed, then, in patients under the conditions I have mentioned, and it is something to be looked for in that particular group of patients.

With respect to the results that have followed the use of streptomycin, I think it is fair to say that this antibiotic has taken its place, along with penicillin, in controlling a large number of infections that were not controlled in the past by the use of the sulfonamides or penicillin. The outstanding results have been obtained, first of all, in tularemia, secondly, in urinary tract infections, and third, in *Hemophilus influenzae* meningitis.

In our own experience at the Haynes Memorial in Boston, we have had twenty recoveries, out of the last twenty-one cases of *Hemophilus influenzae* meningitis, using streptomycin alone, given by the intramuscular and the intrathecal route.

In patients who have bacteremia due to gram negative bacilli, one often finds that the fatality rate in this group is greatly reduced, and that recovery occurs much more often now than it did in the past.

The overall fatality rate in that group of cases is now approximately twenty-five per cent, whereas it was formerly in the neighborhood of seventy per cent.

At the moment, extensive studies are being carried forward by many groups, such as the Veterans' Administration, the Army, the Navy, to determine the place of streptomycin in tuberculosis. It will require a much longer period of observation before we can make any statements as to the position of streptomycin in treating tuberculosis. Up to the moment, we can say that it is the only chemotherapeutic agent available that can be given to patients with tuberculosis that will influence favorably the course in a number of instances.

In patients with pulmonary tuberculosis, with predominantly exudative lesions, it is quite striking to see these exudates disappear in a relatively short period of time, but what is more impressive in many instances is the striking change in the clinical appearance of the patients. Frequently, the temperature returns to normal, the cough lessens, the appetite improves, and these patients improve subjectively as well as objectively in a relatively short period of time.

The results in tuberculosis of the meninges have not been very outstanding, except for the fact that a number of patients with tuberculous meningitis are now recovering. They don't all recover permanently; they have some damage to the central nervous sytem. But, for any patient with tuberculous meningitis to recover following the use of a chemotherapeutic agent is certainly a step forward.

In the treatment of tuberculous sinuses, and tuberculosis of the larynx, the results have been quite striking, and one can observe these sinuses to close and the ulcers in the larynx and the trachea to heal promptly within a period of four to six weeks.

There is very little information concerning its use in bone and joint tuberculosis, or even in renal tuberculosis. The results reported so far in renal tuberculosis indicate that it is a palliative measure, that the amount of pyuria diminishes, the number of organisms decrease and the capacity of the bladder often increases. The dysuria is frequently alleviated.

One can sum up the results in tuberculosis by saying that we do not know the exact position of this drug in the treatment of this disease, but that it is the only chemotherapeutic agent available at the moment that tends to inhibit the growth of the tubercle bacillus and produce positive effects.

In summary, then, I think one can say that with the use of these two agents, penicillin and streptomycin, we have all observed perfectly extraordinary changes in the course of many infectious diseases, and this is something that few of us dreamed of, even as short a period of time as five years ago.

PSYCHIATRIC LESSONS LEARNED IN THE ARMY*

MALCOLM J. FARRELL, M.D.

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It is a very real pleasure and an honor to have been invited to speak at this 136th Annual Meeting of the Rhode Island State Medical Society on some of the psychiatric lessons learned in the last great war. I believe that it is altogether fitting and proper that a portion of this meeting should be devoted to the subject of mental ill health. Our experience in this war has reaffirmed some medical facts which too few of us were aware of in peacetime. Not all of us realized that over half of the hospital beds in the United States were devoted to the care of the mentally ill. If we stop to think we would agree that from 50 to 60% of the patients crowding physicians' offices come because of complaints that are not founded on an organic basis. Rather their illnesses are based on emotional factors. The last great struggle in which our country was engaged brought these facts out in bold and dramatic relief. Without a question psychiatric disturbances presented a great, if not one of the greatest problems to be faced by the Medical Department of the Army. Similarly the post war period is presenting to the medical profession an equally large psychiatric problem.

Inasmuch as there were insufficient psychiatrists, many of you who were in the Military Service, and whose pre-war interests were other than psychiatry, found yourselves assigned many times to psychiatric duty. For better or for worse, the general public has become much interested in psychiatric matters. There have been psychiatric novels, psychiatric movies, books have been written on psychiatry for the layman, newspaper columns have given the subject much space; in short, psychiatry has been receiving an increasing amount of publicity in the past few years, as a result of which the public is much less afraid of the stigma that heretofore existed in relation to emotional illness. The public expects therefore that every doctor will have some knowledge of psychiatry.

The relatively short time at my disposal will not permit me to discuss much more than the size of the problem and the lessons learned from our experience in the Army. There is no doubt among any of us about the remarkable accomplishment of psychiatry in the Army considering the size of the problem with which we dealt, and of the lessons learned. The success of the program was in a large measure contributed to by many physicians who did not have previous psychiatric training.

The places where psychiatrists or physicians assigned to psychiatry served in the Army were numerous. They functioned as members of the Staff in practically every conceivable type of Army medical organization. They were found at the induction centers, they served in many of the 65 regional hospitals, and in many of the 306 station hospitals in this country; in the 217 general hospitals, 196 station and 91 evacuation hospitals overseas. There were 10 specialized hospitals devoted entirely to neuropsychiatry, 8 overseas and 2 in this country. Five of these hospitals were primarily for neurotic patients and three for psychotic patients. One of the greatest opportunities for psychiatric service, particularly in the field of prevention was in the out-patient unit called the "Mental Hygiene Consultation Service". There were 36 of these units established in basic training camps throughout this country where the new soldier who required help, was aided in making a satisfactory adjustment to army life. Psychiatrists were also placed in disciplinary barracks and in centers of rehabilitation and military prisons. The 23 convalescent hospitals were developed largely to meet the needs for more adequate treatment facilities for neurotic patients, who numbered from 30 to 50% of the patient load in these installations. Psychiatrists served in each of the 99 combat divisions. In addition they served in redistribution and separation centers.

The Size of the Problem

Statistics can only roughly describe the magnitude of the neuropsychiatric problem in the Army. They do not indicate the obstacles, the dis-

* Presented at the 136th Annual meeting of the Rhode Island Medical Society, at Providence, May 14, 1947.

appointments, the frustrations or the satisfactions, devotion to duty or the caliber of professional work. They do not reveal the large number of minor mental upsets which never came to the attention of the psychiatrist just as is the case in civilian life. Statistics depend upon diagnoses, and on this point there was considerable confusion within military medical circles which required close study of the situation. The result was the publication of a new nomenclature by the Army which was intended to clarify the situation further. Then too, one could be quite suspicious that some psychiatric diagnoses were made for purposes of convenience. Orders were repeatedly issued to the effect that a diagnosis should not be made in order to expedite the final disposition of a case, but rather diagnoses had to be based on accepted standards. Therefore, when one considers military statistics, one must keep these points in mind.

The latest available figures are essentially those presented by General Menninger who was Chief Consultant in Neuropsychiatry during World War II, at the last meeting of the Psychiatric Association.[1] He states that during the period of Jan. 1, 1942, through Dec. 30, 1945, approximately 1,850,000 men were rejected for military service because of neuropsychiatric disorders. These figures represented 12% of all the men examined and 38% of the men rejected for all causes. From Jan. 1, 1942, to Dec. 30, 1945, there were approximately 1,000,000 patients with neuropsychiatric disorders admitted to Army hospitals. This resulted in a rate of 45 admissions per thousand troups per year and constituted 6% of admissions for all causes to all the hospitals. Less than 7% of these admissions were psychoses; 63% were psychoneuroses and the remaining 30% represented diagnoses of psychopathic personality, mental deficiency and other psychiatric or neurological disorders. Of the million admissions for neuropsychiatric conditions, 40% were among soldiers overseas, and 60% among soldiers on duty in this country. The peak load of psychiatric patients occurred in the month of April, 1945, when there were approximately 50,000 neuropsychiatric patients in our Army hospitals at that time. 380,000 men were discharged from the Army during this same period with medical discharges because of neuropsychiatric disorders. This represented 39% of all medical discharges. In addition to this large number, 163,000 men were discharged administratively for personality disorders which included mental deficiency, psychopathic personality, enuresis and other conditions, which according to Army regulations were not given medical discharges. This made a total of over 500,000 men discharged for personality disorders.

The evacuation figures are also significant during this period from 1942 to 1945. Nearly 19% of the number of the patients evacuated from overseas hospitals were neuropsychiatric. This figure broken down shows that 31% of the patients who were returned in 1942 for medical reasons were psychiatric and following the great increase of battle wounded this fell to 15% in 1945.

The Lessons Learned in Military Psychiatry

Many of the lessons learned in this last emergency had to be relearned from World War I. Many of the difficulties which faced us and which we were obliged to grapple with were clearly outlined in the Medical History[2] of the last war. If the military service during peacetime had kept the lessons learned in the last war more completely in mind, much of the difficulty which we encountered would have been overcome. It is incorrect to believe however, that the military is alone at fault. Organized psychiatry certainly deserves much of the blame. During the peace years no attention whatever was given to the problems of military psychiatry. So that this will not happen again, many of us who were in the military service and who are members of the American Psychiatric Association have banded together in a special Section of the organization. It is the purpose of the Section to keep the lessons learned alive, and to make further plans.

Of course, many new lessons were learned, since this war differed markedly from the last. The fighting itself was far more furious and mobile. It was fought in all climates from the Arctic to the Tropics. It is difficult to place priorities of importance on what we have learned. General Menninger talked of the army as a great human laboratory. It provided a controlled situation in which all men were regimented and lived under the same conditions and presumably all were motivated toward a common goal.

One lesson that we did learn was the widespread misconception regarding the whole subject of mental health in the mind not only of military personnel but of the civilian public, the family back home and the public press. It is generally recognized that the concepts of physical health cover a wide range of conditions, ranging for example, from a light head cold on down to terminal lobar pneumonia. Mental health on the other hand has been regarded as either black or white. Either a man was insane or he was completely normal. The possibility has not been considered that there might be anything in between. Actually, of course, mental health, just as physical health, ranges all the way from good to bad. A man may have a minor temporary mental ill-health just as he may have a head

continued on next page

cold. Mental disorders may be acute or chronic, severe or mild.

A great deal of confusion arose on the basis of terminology and semantics. Any word beginning with the letters "psy" to the average mind suggested something mysterious and alarming, such as insanity, perversion, or homicidal tendencies. Many laymen become frightened and resentful when a psychiatrist applied a medical term to conditions they were used to recognizing as "a case of the jitters" or "gone stale" or "nervousness". It was difficult for the ordinary person to realize that when a case of the jitters became sufficiently serious to incapacitate a man or to produce insomnia and indigestion, a psychiatrist might call it psychoneurosis and yet not mean anything more serious than was meant by the layman who called it the jitters.

A lesson which we learned early in the war was that psychiatric screening in the induction station, although important, was only the first step in preventing psychiatric casualties. It was not to be concluded that the screening process was useless or that, if screening had not been in effect, the number of cases developing in the Army would not have been still greater. Mental defectives, severe psychopaths, psychoneurotics and psychotics were still ineffective as soldiers and could not be used in the Army. The point was, however, that this group of individuals comprised but a small fraction of the neuro-psychiatric cases being encountered. The vast majority were cases of psychoneurosis. They constituted almost all of the neuropsychiatric cases occurring in combat and most of those returning from overseas. Similarly, the greater part of the neuropsychiatric cases admitted to hospitals in the continental United States and the greater part of those discharged from the Army were psychoneuroses. Furthermore, considerable evidence accumulated which indicated that a large portion of these cases were occurring in individuals whose past history was negative for neuropathic traits or anything that could be taken to indicate predisposition to psychiatric disorders. The myth that only weaklings developed psychiatric disturbances was finally exploded completely by early reports from combat theaters where the problem was carefully studied. It was found in one campaign that the incidence of psychiatric cases was uniformly higher among veteran combat troops than among fresh green troops. Months of intensive combat had weeded out all of the weaklings and the men who remained had proved the toughness of their underlying personality structure by their mere survival. Yet fatigue and other factors produced more "psychoneurotics" in this group than among fresh, untrained troops. In short, it became evident that anybody could develop a psychoneurosis under certain circumstances particularly if sufficient stress was applied. The limitations of screening became obvious. It could not be expected to have any effect whatsoever on decreasing the rate at which "normal" men broke down. It further ran the risk of eliminating men who, although having some defect of the personality, nevertheless, if properly handled, could render valuable service in the Army. Extensive studies were made both of troops successful in training and of troops who had gone through intensive combat without developing psychiatric disorders. The results, although they corroborated the general impression that the incidence of neuropathic traits was higher among men that had broken down than those who had not, nevertheless, showed that there were a great number of men successfully making the grade and doing good jobs who admitted to having many of the signs and symptoms ordinarily taken to indicate weakness of the personality. For instance, among soldiers on duty in the continental United States, a significant percentage admitted nail biting; said they had sick headaches; had been bothered by nightmares; by "upset stomachs"; by nervousness; by frequent insomnia; by dizzy spells; and by frequent palpitation. It is very probable that the incidence of these same signs and symptoms are considerably higher among so-called "normal" civilians. This impression should teach us that in our civilian practice we should not pay too much attention to individual symptoms but rather to the entire personality and its adjustment to every day life.

Another very important and impressive experience of military psychiatrists was the recognition of the importance of external stress in precipitating personality disorders. The existence of psychiatric determinants as such, the history of maladjustment in the family or the individual, did account for many of the casualties. On the other hand, far more impressive was the power of factors in the environment which supported or broke the individual. We learned early that the maintenance of mental health was largely a function of leadership and included the extremely important element of motivating the soldier to do his proper part, and closely identifying with his associates and unit. The absence or weakness of any of these factors in the presence of many excessive stresses seemed to account for a large number of psychiatric casualties. The same factors are applicable in civil life. Each person desires security and needs to feel that he is a member of the community and all that implies.

It is well recognized that there are few, if any, situations in civilian existence comparable to military life. The separation from home and loved ones and comparative freedom had to be given up for regimentation, discipline, lack of freedom and

the physical stress of training. This was sufficient to produce breakdowns in many individuals. For those who survived the training period there was the prospect of shipment overseas through dangerous waters to the far corners of the world, living in extremes of climate, being exposed to constant danger, with few of the comforts and luxuries of everyday home life. Should the individual survive all these, he was then faced with the supreme test of surviving the ordeal of combat, which certainly has no counterpart in civilian life.

It may be surprising to many of you to discover that only 7% of the hospitalized psychiatric patients were psychotic. Early in the military emergency the Army made provision for many times that number of psychotic patients. As a matter of fact as late as 1941 the Army thought of psychiatry largely in terms of disposition of psychotics. It was not until sometime later that treatment was organized in the Army and provisions made for the large number of psychoneurotic patients which appeared. All of this in spite of the fact that Colonel Thomas W. Salmon[3], Chief of Neuropsychiatry in World War I reported, "psychiatry has concerned itself almost exclusively with insanity. Today that term is properly applied to only a relatively small proportion of all persons in whom psychiatrists are interested."

Another lesson learned was that the teaching of psychiatry in medical schools fell far short of its objective. Many medical officers were inadequately equipped even in the rudiments of psychiatric understanding and treatment. What is perhaps even more important and serious was that few had any interest in psychiatric matters and many openly boasted proudly that they knew nothing about them and did not want to have anything to do with them; all this in spite of the fact that the psychiatric problem was one of the greatest that the Medical Department had to face.

There was a very great shortage of trained personnel, not only of psychiatrists and neurologists, but of psychologists and psychiatric social workers. Of the 2400 medical officers assigned to neuropsychiatric duty, only approximately 800 had psychiatric experience prior to the war. The remaining number were trained in the Army and most of them attended an intensive three-months' course in neuropsychiatry before assignment. Much to our surprise this group did a splendid job. We also had to provide training for clinical psychologists, and we had to train individuals in the A.B.C.'s of psychiatric social work. Not until after the war was over did we have anywhere near enough trained personnel to do the job. In many instances the Neuropsychiatric Service of a hospital comprised more than half of the entire Medical Service in that hospital. To handle these large numbers, less than 3 to 5% of the physicians were assigned to psychiatry. As General Menninger[4] has stated "We offer no apologies for our personnel though we are frank in the admission that many of them were inadequate personally and professionally, including many of those who had had prewar experience in psychiatry."

Once our treatment program got well under way, it was evident that when extensive early treatment was provided in an atmosphere of expectation of recovery, remarkable results were obtained. Even with stream-lined treatment methods, a remarkable recovery rate occurred. This was true in combat areas where 60% were returned to duty within a few days, and an additional 30% within a few weeks. In our hospitals in this country, which received only the most resistant cases from overseas, it was possible to return an additional 15 to 25% of combat casualties to some kind of duty and to send the great majority of the others home much improved. Remarkable results were observed in the recovery rate of psychotic patients who so often become custodial patients in civilian hospitals. Possibly because of early recognition, partly because of intensified treatment, seven of each ten psychotic hospital admissions in 1945 were able to be discharged to their homes. Of one million neuropsychiatric hospital admissions there were only 380,000 men discharged from the Army. Many of these were hospitalized prior to 1944 when the treatment program was officially approved for psychiatric patients in the Army. This naturally leads one to the conclusion that if we could educate the public, if we could adequately staff our clinics and hospitals, and if, above all else, we could emphasize and practice intensive early treatment, we could revolutionize the rate of recovery of mental illness.

Throughout military experience we discovered the undeniable fact that leadership was of great importance in the preservation of mental health. With good leadership, a soldier had the inspiration of emotional attachment to his superior officer, and this attachment was most important in order to accomplish the mission of the unit. We seemed to learn anew the importance of group ties in the maintenance of mental health.

We were greatly impressed by the fact that an individual who had a strong conviction about his military service and realized the reasons why he was in the military service, even though he was of unstable personality, might make a remarkable achievement against the greatest stress. We saw again and again the relationship between how people feel and believe, and think, and the resulting mental incapacity.

We early learned another lesson, and that was the great social need for psychiatry. There was a

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great need for the application of its principles to many activities which were not directly concerned with diagnosis and treatment of illness. We saw the need for the use of psychiatric principles in selection. Although we never accomplished it in the American Army, we felt that psychiatric study should be a cornerstone in the selection of officers as it became in the British Army. We could see that psychiatry could make a great contribution to the solution of the problem of getting the right person in the right job. We saw the results of misassignment which in so many instances directly contributed to the development of a psychiatric casualty. We had extensive training in its application to penology and realized that further definite contributions could be made in that field.

Another lesson learned was that in the majority of cases long and expensive treatment was not necessary. Because there was so few psychiatrists and so many patients, short cuts in treatment had to be developed. This was the only way of saving time for the psychiatrist so that he could have contact with more patients. The development of group psychotherapy and the extensive use of hypnoanalysis and intravenous abreaction adequately demonstrated that such methods were feasible. No longer was it necessary for a psychiatrist to see and treat only six to eight patients a day, since much time and effort could be saved through the use of these new methods, thereby allowing more patients to have the benefit of treatment.

Those of us who struggled with the immense psychiatric problem had the feeling that much could have been accomplished in the field of prevention. The surface of this problem has hardly been scratched. We had every reason to believe that had we had the manpower to devote the necessary effort and time to the preventive aspects of psychiatry, such as was given to the preventive efforts of internal medicine, we too could have perhaps demonstrated spectacular achievements comparable to vaccination or D.D.T.

In conclusion, we felt that psychiatry in the Army did a reasonably creditable job, primarily because of the devotion, integrity and ability of a handful of men and women. It goes without saying, however, that organized medicine and its members have a wide challenge confronting them in the community. The medical profession must take a more active interest in emotional disorders. It will not be sufficient to say to the emotionally ill "you are only nervous, there is nothing wrong with you, all you need is a rest". Such an attitude will drive them to become victims of quacks and charlatans. The proportion of individuals coming to doctors for emotional disorders is very high. The medical profession must take on the attitude of the student, that is, the willingness to learn in order to help these people. There are not enough psychiatrists available, neither should it be necessary for patients with mild emotional disorders to be referred to a psychiatrist. They expect to be, and should be treated by physicians in general practice.

In the field of psychiatry, as in any other field of medicine, prevention is of primary importance. Certainly no other medical person has access to so many homes in such a variety of situations as the general practitioners. No other person has such an opportunity to recognize early signs of mental disorder. Early treatment is tantamount to early recovery. Here much can be accomplished in helping to dispel the popular misunderstanding and misconceptions concerning mental ill health. Families often dismiss mental upsets in their members as mere nervousness. They feel that such conditions are a disgrace, that they are effective only temporarily, and at the same time they believe that time will solve the problem. The physician's counsel is of great value to the family whose thinking has become so subjective that a clear conception of the best procedure to adopt for its ill member is impossible.

Your organization must join with the psychiatric organization to consider this great problem. We must not let these lessons be forgotten. We can agree with General Menninger[5] when he said "we can not become too complacent or too smug to follow up on these challenges. Our best hope lies in the cohesion of our forces in a plan of strategy, a conviction as to the importance of the job and a militant leadership."

But we as individuals also have responsibilities. If we can only use our influence for the benefit of peace time mental health, another lesson will have been learned. More realistic thinking during the past two decades should have prevented many of our young men's maladjustments in the Military Service.

We failed to imbue in many the fervors and convictions that would enable them to withstand the rigors and unpleasantness of military life. Too long, we stressed the rights and safety of the individual, at the same time giving little thought to the rights and security of the group. Our country found itself ill prepared for war, and our citizen soldiers even less prepared mentally for the struggle. We asked our young men to submerge their individualities in mass team work. Small wonder that some of the players in the grim game had to drop out.

We and they paid heavily for twenty years of wishful thinking. Let us not make that mistake again.

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TRENDS IN PART-TIME INDUSTRIAL HEALTH SERVICE*

CRIT PHARRIS, M.D.

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THE SUBJECT "Trends in Part-Time Industrial Health Service" was selected for discussion for the reason that a majority of industrial physicians are employed on part-time bases, and are supplying the types of medical services available to a large majority of industrial workers. The problems confronting part-time physicians are more complex than those usually experienced by full-time physicians, even though the scope of the programs they engage in differ, theoretically, in extent rather than quality.

There probably is not a branch of medicine which is undergoing more drastic changes today than industrial medicine and, I might add, there also probably is no branch of the profession offering greater opportunities for improvement. This opinion is expressed notwithstanding the fact that many plant health services, part-time as well as full-time, are providing thousands of industrial workers with efficient health care. The fact still remains, however, that, in so far as attitude and support by industry and labor are concerned, there still is too much prejudice, lack of appreciation of good health services and general unconcern. Such opinions are due, in some instances, to lack of opportunity to see a good medical program at work. There still are too many inadequate services in industry which, not only are not worthy of wholesome support by management and employees, but which also are barriers to the progress of good medicine both in and out of industry.

Historical Review

Industrial medicine is one of the newest branches of medicine. There were a few isolated examples prior to 1900 but, generally speaking, industrial medicine really came into existence following the passage of Workmen's Compensation laws in the various states. These laws forced management to provide medical care for industrial cases, and it soon became evident that it was cheaper to bring the doctor to the cases than to send the cases to him.

Industrial medicine got its start in a majority of plants through compulsion. The doctor was employed because the law required it and the attitude was to have him take care of accident cases and do nothing else.

The plant official often selected his own family physician or went out in the open market, so to speak, and shopped for a cheap one. In either case, the physician often had no specific knowledge of industrial medical problems and had little interest in anything except the treatment of the injured workers. Such physicians previously had "pro-industry" attitudes or they soon developed them. Their duties, as they saw them, were to take care of the company's interests, and this they usually did, without too much consideration being given to the fact that what actually was to the best interest of the company also was to the best interest of the workers and the medical profession as well. Some of these physicians also became "pro-Insurance Company" in their attitudes, thus further widening the breach between industry and the workers on the question of industrial medicine.

All of these adverse conditions also had their effect upon the attitude of the medical profession. Many early plant physicians were judged harshly by their colleagues because they were willing to stoop low enough to become "plant doctors," or even to accept "insurance cases" in their private practices.

These and many other factors seriously handicapped industrial medicine at the outset and their retarding influences have not yet been entirely eliminated. There was another side to the early picture, however, which cannot be overlooked because it is to it that we owe the credit for all the good qualities of industrial medicine.

Some plants had the correct attitude toward employee health even before the passage of compensation insurance laws. Others soon were able to see that they could effectively promote good employee relations by providing competent medical service and, at the same time, make the investment pay substantial dividends by improving employee health through preventive medicine.

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* Presented at the 136th Annual Meeting of the Rhode Island Medical Society, at Providence, R. I., May 15, 1947.

Such organizations procured physicians who were competent in attitude and perspective as well as in the practice of medicine. The physicians were not "pro-industry," or "pro-labor." Their conduct seldom was challenged and they had the support of both management and the employees.

The scope of service rendered by these earlier doctors naturally was not as comprehensive as it is today. Some of them specialized in surgery, others in general medicine or in some special phase of medicine. In doing so, they may have neglected certain problems because of insufficient knowledge or interest. Yet, when we look upon the accomplishments in a collective sense we realize that the sum-total of all these individual efforts, both generalized and specialized, set the standards of good industrial medicine for succeeding generations of industrial physicians to follow and improve.

Present Day Attitudes Toward Industrial Medicine

The present day attitude of industry toward industrial medicine is based upon past experiences. If industry is seeking the assistance of the medical profession in the extension and improvement of plant health programs, the sign is good. If, on the other hand, the average plant still is content to use doctors to the least extent permitted by law, the reason probably is due to lack of knowledge concerning the advantages of a modern plant health program.

The attitude of employees is a very reliable indication of the quality of medical service they are receiving. If they utilize and respect the services provided by their employer, even in states where they have free choice, this speaks very well for the medical program. If, on the other hand, a majority consider the doctor as a "quack," a "butcher" or an unfair "company doctor," they probably are correct.

The attitude of the medical profession as a whole toward industrial medicine also is highly significant. Many medical societies are demonstrating the same type of good faith which your organization is displaying by actively promoting better plant health programs. This type of support is essential. With it, the industrial physicians can go a long way but without it, they are faced with very serious handicaps.

The average plant today is receptive to any practical suggestions which will be for the improvement of industrial health standards. Management has learned that good health and good employee relations are closely related and that without them, production suffers. Yet, industry still presents a frontier to industrial medicine which has been only partially developed. The extent to which this territory is opened up rests largely in the hands of the medical profession. There already are enough potential purchasers of modern plant health programs to seriously tax the abiliities of most medical groups to deliver. This degree of receptiveness is proof enough that whatever the earlier handicaps were like, industrial medicine is now out in front.

Further evidence of this progress is to be found in the interest which The American Medical Association and the various state and local societies are taking. Your own efforts are an example of what is going on throughout the country. This interest is being expressed along two basic lines. Considerable emphasis is being placed upon the study of medical problems peculiar to industry. Medical schools are offering undergraduate and postgraduate courses in increasing numbers. Seminars, clinics and special conferences are common today but they were rare as recently as ten years ago. The medical profession as a whole, and many individual physicians, are at last definitely convinced that however skillful or successful a physician might be in dealing with general health problems common to the community, he might be a failure, in handling industrial cases. The fact has been demonstrated that industrial medicine and general medicine are not necessarily one and the same, but that success in the plant practice can be measured by the special knowledge the physician has of medical problems peculiar to the plant.

The other basic approach of the medical profession toward the improvement and extension of industrial medicine deals with the consumer. Lay information, graduated for both industrial officials and workers, is being disseminated in various ways. One of the most interesting recent approaches along this line is the cooperation given by the profession in the organization of demonstration services. The objective here is to assist a group of small plants in employing part-time medical and nursing care under a plan of joint guidance until the merits of a modern health program have been demonstrated. The idea from here on is for the plants to provide on a continuous basis whatever amount of such services their problems and size merit.

Through such demonstrations, the employees are given an opportunity to sample the benefits of a progressive preventive medicine program which adds to, rather than stints, basic medical care to which they are entitled by law.

These demonstrations unfortunately are quite late. Had it been possible to do more educational work along this line during the earliest days of industrial medicine, many mistakes would have been

avoided. Both industry and labor would have learned early what many of them are just now learning, namely, that a plant health program voluntarily dedicated to the prevention, as well as treatment, of job-connected disorders can be far more beneficial than one conceived through compulsion and confined to the minimum services required by law.

Another favorable sign is the extent to which physicians are going into industrial practice. They are turning toward industry in greater numbers than ever before. Some are undoubtedly interested solely as a temporary security measure until they become established in other branches of the profession. Others simply are looking for easy jobs and do not realize what is involved in the practice of modern industrial medicine. It is undoubtedly true, however, that a very substantial number are interested in industrial medicine as careers and they will become valuable assets to the profession.

Trends in Industrial Medical Services

As to the scope of future plant health programs, there also are many favorable signs. Some of them have been referred to already in this discussion, others are just now putting in their appearance, and cannot be too clearly analyzed at the moment. It does appear evident, however, that all signs point toward the rounding out of services which will strike proper balances between therapy and prevention. Some individual programs still are top-heavy in one direction or the other and, in some instances, too much time is being wasted on fads or relatively unimportant problems. It is my opinion that the most significant trends are concerned with the improvement of services which have been recognized as within the province of industrial medicine for a long time. Consequently, I should like to discuss a few of them briefly at this point.

Treatment

The treatment of job-connected disorders still is the fundamental function of the plant medical department. This function will maintain its present importance until a much better job is done in preventing industrial disabilities. Along with the improvements in techniques and skills of rendering this service, plant physicians are devoting more attention to the physical, physiological and psychological circumstances of the individual in relation to the environmental factors which cause or contribute to injuries and illness.

The earlier tendencies in some plants of handling industrial cases on an impersonal basis are disappearing. Industry is becoming increasingly aware of the fact that medicine, in as well as out of industry, is only good to the degree that its eventual application is based upon proper consideration of the individual. This newer appreciation of the value of good medical and surgical care is based upon a growing conviction that management's best interests are thus served. Many labor relations problems in industry grow out of poor and discourteous handling of cases. The ultimate effects of such disorders may be far reaching. Good conduct on the part of the medical staff may result in the elimination of such industrial problems.

So, the trend in so far as treatment of cases is concerned is to provide adequate therapeutic care. Whether the case is handled in the first-aid station, nursing station, plant hospital, or by consultants, does not alter the importance of making every effort to constantly improve the quality of care given. Just as many first-aiders have given way to registered nurses, so have many incompetent physicians been replaced by good ones.

Physical Evaluations

Physical examinations, functional capacities evaluations and proper placement of handicapped individuals have undergone greater improvement recently than perhaps any other phases of industrial medicine. Here again management has taken a very stimulating lead. The earlier attitude of using physical examinations simply as a means of eliminating the undesirable and employing only the so-called physically perfect still exists in some plants. Industry still is interested in eliminating the totally unfit and, in this sense, the objective of physical examinations has not changed. The real change is in interpretation of who is fit or unfit to work, and in the varying conditions under which physically handicapped people can be employed profitably.

The first interest which management has in a prospective employee concerns his skill to do the job. The factor of next importance is physical fitness. If both qualifications are above question the problem of placement is simple. It often is the case, however, that the man has the skill but there is some question about his physical ability. It is here that the examining physician always has been called upon for assistance. The assistance originally called for was as to whether, in the doctor's opinion, the man should be given the job.

The present-day trend in physical examinations is to make a more comprehensive examination than was the earlier practice. Various special tests and procedures are employed such as x-rays, electrocardiograms, audiograms, blood serology, etc., in order that a better diagnostic job can be done. The superficial examination, which often involved little more than a brief physical inspection, was not worth very much to anybody. Industry is ready and willing to provide better diagnostic services

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and the employees as a whole are better satisfied with them.

Evaluation of functional capacity is a natural and necessary companion procedure to physical examinations. The foreman is not much concerned about what is wrong with the individual. He wants to know what the man is physically able to do. This information can be given out without revealing the diagnosis, and in a manner which will tell the foreman what he needs to know about the man's ability to lift, climb, stand and engage in the other activities required by the job. Some functional capacity reports contain general information along this line with little or no reference to the degree of exertion possible, or the percentage of the shift time the man can be expected to engage in the various physical activities. The trend seems to be toward giving the employer such information in terms of the approximate percentage of the shift time the man can reasonably be expected to exert himself and the extent to which he may safely exert himself in carrying out the various physical activities. Precise evaluations cannot be made in these respects for obvious reasons but the physician can make more intelligent and accurate estimates than can be arrived at through superficial examinations and broad negative recommendations concerning what the man cannot do.

The success of any physical examination and functional capacity evaluation program depends primarily upon the skill employed in making the examinations, plus the translations of the findings into usable positive suggestions concerning both the general degrees of residual physical capacity and the extent to which the employee can be expected to draw upon these reserves while doing his job. It is essential that the examining physician be thoroughly familiar with the physical activities and hazardous exposures in the plant, otherwise he will be falling down on the total job regardless of how skillful he might be as a diagnostician, or the extent of his knowledge concerning the basic reserves which individuals can utilize in the face of disabilities. To gain this broad knowledge concerning shop conditions, the physician preferably should make personal studies of working circumstances or, at least, have access to precise job analysis data.

Periodic examinations are becoming more popular in industry. They are as essential in keeping up to date on the status of health as inventories of materials and equipment are to the operation and management of the plant. Too much emphasis has been placed upon shop-wide general physical examinations and not enough thought has been devoted to modifications in order to include the diagnostic procedures called for in evaluating effects of exposure to specific hazards. It usually is satisfactory to examine office workers annually but others might need to be examined every six months or even more frequently. It also might be very important to make complete blood counts, quantitative determinations of lead in the urine, or employ other special procedures not normally indicated in the examination of office employees. The trend is toward more extensive use of annual physical examinations in industry but emphasis is being placed upon the graduating of the types and intervals so as to adequately evaluate health progress in relation to the specific hazards of the job.

Industrial Hygiene

Industrial hygiene is a service which when defined in its broadest sense, covers the total preventive medical picture. Another conception of the service relates specifically to the evaluation and control of occupational health hazards. This more restricted definition is followed in this discussion.

Industrial hygiene may utilize the talents of a wide variety of specialists but the basic triumvirate includes the physician, the chemist and the engineer. These three, working together, provide information concerning the physical consequences of exposure, the type and concentrations of the hazardous materials and the corrective steps which should be employed. Working separately, they often can accomplish beneficial results, depending upon the nature of the problem involved. The greatest good usually can be realized, however, through pooling of resources, and this cooperative effort is a typical example of the interdependence of various special interests in the conduct of most phases of preventive medicine.

The plant physician generally has lagged behind in his participation in industrial hygiene. This is particularly true for plants not having their own industrial hygiene chemists or engineers. Industrial hygienists sent out by official agencies often deal with plant engineers or foremen and do not have the opportunity, or take advantage of it, to work with the physician while in the plant. Such instances should be eliminated and the trend is in this direction. The physician is, or should be, the authority in the plant concerning all technical aspects of employee health.

General Environmental Conditions

General plant health conditions related to food handling, toilets, drinking facilities, plant housekeeping, etc., too often are passed up by the plant physician. For this reason, as well as others, some plants still have "slums" which are as abominable as those to be found in the poorest residential areas.

Active interest in such sanitary conditions by the plant physician usually will lead to improvement.

Safety

The role of unsafe acts growing out of physical, physiological and mental maladjustments has been appreciated for a long time. The interest shown by plant physicians in such problems has lagged considerably behind that of the safety engineers. The principal reasons are that many physicians do not appreciate or admit the interdependence of medical and safety programs. Some safety engineers also are short-sighted in this respect and are not inclined to encourage cooperative effort. The earlier conception that safety services should deal primarily with machine guarding and other nonhuman causes of injury was appropriate enough at the time because such unsafe conditions were common and they gave rise to many spectacular and serious injuries. This picture has changed greatly, however, and no longer should be considered the principal interest in the average plant.

Unsafe acts which always have been important causes of accidents are becoming greater in relative importance because the mechanical causes are decreasing rapidly. Increased knowledge concerning accident prone and accident habit characteristics of employees has further high lighted the importance of the human elements responsible for accidents. It is a well known fact that a large majority of accidents are due to these faulty human factors and that such faults predominate among about one-third of the employees. The reasons why one-third or less of the workers cause two-thirds or more of the total accidents vary in type and complexity. The diagnosis and control is simple in many instances but there are others which are not yet amenable to solution.

The interests of safety engineers have definitely shifted toward the more complex realm of accident causes which they commonly refer to as unsafe acts. They are looking to the medical department for more assistance and the response is generally quite favorable. Plant physicians are combining epidemiological inquiry and tactful safety instruction with therapy in a manner which not only improves the therapeutic approach but further individualizes it and utilizes the injury as an object lesson in safety which the employee will remember and pass along for the benefit of uninjured fellow workers. In the course of such dealings, the plant physician gets information which permits him to identify the behavior pattern of the individual. This pattern may be influenced principally by physical defects, physiological incapacity or temperamental disturbance. In any event, the doctor renders an invaluable service to the cause of accident prevention by advising the safety engineer and the foreman as to the corrective steps which should eliminate subsequent trouble.

A Survey of Health Services in Rhode Island

As was stated earlier in this discussion, no attempt was made to mention all of the trends in industrial health service. Neither was it my plan to deal extensively with the examples used. It is felt that the remarks have high lighted some of the more important trends which not only can be evaluated logically but statistically as well. It would seem appropriate at this time to look at the score sheet to see just how far we have traveled toward achievement of some of these goals in industrial health. Numerous national and local surveys of one type or another have been made during recent years. The general findings reveal much encouraging progress but, on the other hand, they reveal many shortcomings.

The status of industrial health coverage in Rhode Island can be illustrated briefly, I believe, by examining the survey findings of an Insurance Company[1]. This survey, made recently, covered nineteen plants located throughout the state. The industries involved probably were slightly substandard in some respects but they were considered to be fairly representative to the extent to which certain plant health facilities and services have been provided by the average plant in the state.

These nineteen plants employed a total of 17,165 workers. The population in each ranged from 125 to 6,500, with the average for the group being about 900 each. By and large, the extent to which the services and facilities were provided was in proportion to the number of employees but there were some exceptions. For example, one of the smallest plants rated along with the best while some of the others with larger populations rated rather poorly.

Seven of the plants employing 12,574 workers employed physicians on a regular schedule basis while the others only called a doctor in when they felt the need to do so. Qualified nursing service was provided full-time by twelve plants employing 14,564 people. Of the other seven plants, which averaged 370 employees each, one had a qualified first aid attendant but the others had no nursing or first aid service measuring up to adequate standards. These same plants also depended upon on-call medical services. Eleven plants employing 13,764 workers provided pre-placement physical examinations but only four of them made studies of physical demands and hazards of jobs. These four plants had 8,945 employees so it appears that the 4,819 workers in the other industries providing pre-placement examinations were examined and placed without the benefits of physical demands

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and hazards data. It is possible, of course, that the examining physicians possessed adequate first hand knowledge of shop conditions by which they were guided in their pre-placement examinations.

Seven of the plants had basic standing orders concerning the handling of cases in the absence of the doctors. Yet, there were five plants employing full-time nurses, in addition to seven not having any nursing care, which did not have standing orders. These latter plants had 6,295 employees, or an average of about 525 each.

In so far as the adequacy of case-handling equipment was concerned, nine plants were rated as adequate or good, eight were below standard and two plants employing 400 and 425 workers, respectively, had no such equipment.

The evaluation of sanitation standards showed that five plants rated good, five were fair and nine were poor. The plants with poor ratings employed 5,060 workers with an average of 562 each. Two of these plants each had over one thousand workers.

The survey report from which the above figures were taken made no specific reference to the quality of services rendered but some obvious conclusions can be drawn. In several plants the services simply did not exist beyond that procured when doctors were called in, or that which was given by inadequately qualified employees. Nothing can be concluded concerning the scope or adequacy of the services rendered by the physicians and nurses employed but it is only fair to presume that they were at least equal to those prevailing throughout the state.

The findings in these nineteen plants have not been used for the purpose of describing industrial medical service in Rhode Island as poorer than those existing in other states. Some states may be somewhat better off but there undoubtedly are others which do not rate so well. The real purpose of discussing the survey findings was to illustrate the general state of development of industrial medical service throughout the country. Although this small sample of plants is statistically inadequate to justify any positive conclusions being derived from the data presented, the impressions are similar to those gained from an analysis of more extensive surveys. The general conclusions are that millions of workers in the country still are being deprived of the type of care which promotes better individual and group health.

Summary

In this discussion, I have given my own impressions concerning the present status of industrial medicine and what some of the trends are. In presenting these impressions and opinions, I have briefly reviewed the history of industrial medicine and attempted to summarize present-day attitudes and accomplishments as influenced by the earlier developments. The earlier developmental problems have left their impressions, some of which are good and others bad. It is obvious that industrial medicine is coming into its own rapidly and on a basis where industrial officials and employees are not only more receptive than in the past, but are becoming more and more insistent that they get good health protection.

The extent, and rate of development, of plant health programs naturally will be governed by economic conditions, specific plant hazards and other factors, but such handicaps will only have retarding influences. The trends concerning quality and quantity of service will not be reversed. The rate of development naturally will be governed quite largely by the attitude and effort of individual physicians and their medical societies. Success along these lines will depend upon the extent to which plant physicians, industrial health committees and the medical profession as a whole condition themselves to deal with the various health and safety problems as being something apart from nonindustrial practice. The next step is to demonstrate the advantages of modern health care through good individual plant programs and group participation in efforts to further enlightening industry and labor as to the benefits they should realize. The indications at the moment are that these goals will be reached and that the medical profession will do its part in bringing adequate health protection to all industrial workers.

Reference

[1] Loss Prevention Department, Liberty Mutual Insurance Company, Boston, Massachusetts.

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ELIZABETH A. SANTOS

57 Stokes St. Conimicut, Rhode Island

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"BLIND EXPERIMENTS OF TOTALITARIAN RULE"

THE STATEMENTS of junior Senator J. Howard McGrath of Rhode Island before the U. S. Senate Committee on Labor and Public Welfare on the proposed compulsory national health insurance act which the Senator is co-sponsoring, represented in our opinion a series of contradictions in the light of Mr. McGrath's experience in our State.

Let's view one or two of these profound opinions of Senator McGrath.

He attacks the American Medical Association as no longer acting in the interest of the people or the doctors.

The American Medical Association is the medical profession of this country. It is a federacy of the state medical societies, each a sovereign unit just as is each of our state governments in relation to the Federal government. The Rhode Island Medical Society elects a delegate to the House of Delegates of the American Medical Association even as the people of this state elect representatives to Congress. Our Delegate speaks not his personal decision on matters of health and medicine, but rather the stated opinion of the Rhode Island Medical profession even though that opinion runs contrary to his personal likes.

Therefore when Senator McGrath charges the American Medical Association with "undemocratic functioning" he has his tongue well in his cheek. When 268 Congressmen wanted to reduce our taxes recently but 137 plus one Presidential vote said "no", we accepted the inconsistency as part of the democratic process of government. And if Mr. McGrath in his testimony was indicting any officials of the American Medical Association as refusing to carry out the instructions of the doctors of America he should submit proof and give names, and not generalize falsely by indicting the entire medical profession.

Senator McGrath stated relative to Rhode Island that "the State is not afraid of the bugaboo of compulsion" and that "no comprehensive health insurance bill can be truly effective unless, as has been demonstrated by worldwide experience, the employer pays part of the cost." No, we're not afraid of the bogey man, but we are mighty fearful of any plan, federal or state, that will place in the hands of a political bureaucratic entity the complete control of any major phase of the American way of life and living. Anyone who has studied the records knows that European experience in health insurance such as Mr. McGrath would import to our shores has produced no where near the high standard of health care existing in this country.

And if Mr. McGrath is convinced that a sickness benefit plan must have employer financial support to be successful why did he allow the Rhode Island Cash Sickness Compensation plan to be introduced

continued on next page

and continued under his governorship at the complete expense of the worker who was never given a chance to say whether he preferred the continued tax or an addition in his take home pay?

Senator McGrath states that the compulsory program on a national basis is the only answer. He does not speak from his own experience in Rhode Island when he makes this strong bid for the advancement of socialism in America.

In 1943, Mr. McGrath accepted—six days before the R. I. General Assembly convened for the 1944 session—a proposal worked out by a representative of the Rhode Island Department of Social Welfare for a compulsory hospitalization law that was socialistic in its theory and procedure. Subsequently the proposal was studied by a statewide voluntary health council, picked by Mr. McGrath, that included in its membership representatives of industry, labor, insurance, banking, the clergy, and the medical and legal professions. The proposal was turned down in favor of the advancement of the voluntary method, and at that time, just two and one half years ago, Mr. McGrath stated he believed

> "we are perhaps making as rapid progress under the present (voluntary) system as we could make under compulsory hospitalization, which, without experience, we would have to limit to such groups as are now covered by unemployment insurance and other social programs."

and he further stated at that time that

> "as a result of our study we have found that the pathway to compulsory hospitalization is beset with trials."

Since in the intervening time the Blue Cross, with the support of organizations throughout the state has increased its statewide coverage from 38 per cent to 70 per cent of the population, and the Rhode Island Medical Society is completing its plans for a prepaid voluntary surgical insurance plan to be added to those already operating in 37 other states, it would appear that Mr. McGrath has lost sight of Rhode Island health interests since taking his residence to Washington.

We commend to Senator McGrath his own words, spoken to the Rhode Island General Assembly in 1943, when he said

> "We have been accustomed to see our type of government largely accepted throughout the civilized world. But the two years that have passed since we last met to inaugurate a State government have witnessed terrific political and military upheavals. Today, we, along with our sister States of the Western Hemisphere are fast becoming the last organized societies in which a drama like this can be enacted. Upon our conduct, in the administration of this representative government of free men, depends whether or not an opportunity will exist, even here, to repeat this scene two years from now. It is certain that the world through the power of our example and the practical effectiveness of our type of government to provide people the kind of social, political and economic progress they crave, will either return to the Democratic way of life, or will be driven to further pursue blind experiments of totalitarian rule."

We have had enough blind experiments of totalitarian rule. We believe the people of Rhode Island favor progress by evolution, not by revolution. The willingness to bear the entire cost of cash sickness disability compensation and to top the nation in the purchase of hospitalization service offer ample proof of the desire of Rhode Islanders to solve their health care problems in the American way.

In his zeal for a federal bureaucratic program of additional compulsory taxation, Mr. McGrath, as an exponent of the principles of Thomas Jefferson, should heed that statesman's words that "considering the general tendency to multiply offices and dependencies, and to increase expense to the ultimate term of burden which the citizen can bear, it behooves us to avail ourselves on every occasion which presents itself for taking off the surcharge; that it may never be seen here that, after leaving to labor the smallest portion of its earnings on which it can subsist, the government shall itself consume the residue of what it was constituted to guard."

Our Democratic process guarantees the right of free speech. Mr. McGrath is entitled to express his personal views, but his statements as a public servant warrant consideration of the expressed opinions of the electorate that sent him to Washington to advance the American way of life under which he himself appears to have prospered exceptionally well.

DOCTOR WHEATON HONORED

The medical staff of The Memorial Hospital, Pawtucket, Rhode Island, honored James L. Wheaton, M.D., by presenting his portrait to the board of trustees of the hospital on July 9, 1947 on his 79th birthday. Dr. Wheaton was instrumental in the founding of the hospital in 1910 through his friendship with the late Frank A. Sayles and has been active in the affairs of the hospital since that time.

RICH ASSOCIATES REPLY TO McGRATH TESTIMONY

The testimony presented to the sub-committee on health of the Committee of Labor and Public Welfare of the U. S. Senate by Senator J. Howard McGrath of Rhode Island was submitted to Mr. Raymond T. Rich, chairman of Raymond Rich Associates who are mentioned in Senator McGrath's statement.

The telegraphic answer of the Rich Associates is as follows:

(July 23, 1947)

John E. Farrell,
Rhode Island Medical Society
106 Francis Street
Providence, Rhode Island.

I appreciate your letter. We have requested the Chairman of the sub-committee on Health of the Committee of Labor and Public Welfare of the Senate to read the following statement into the record:

"The statement to your committee by Senator J. Howard McGrath on July 11 accurately quotes the substance of our final report to the American Medical Association. However, in order to avoid a possible confusion of the record, we wish to state that in the course of our work for the American Medical Association we found that with respect to government control of medical economics the Trustees generally reflect the present views of the majority of American doctors."

Raymond T. Rich, Chairman.

PRECEPT AND PERFORMANCE

We have just addressed a very personal question to a caller. We asked him what his income tax was and he said it was $500 a year.

We then asked this caller how many tons of coal he used each year. He said eight.

So if the price of his coal should go up by $1 a ton, his added cost of living would be $8 for the year. President Truman is very eager that the coal operators should not take this $8 from the man and in a statement Monday expressed such hope.

On the same day, President Truman again let it be known that he would veto the tax bill which is to come to him from Congress. The tax bill would reduce our caller's income tax by $100 a year.

It is very bad to charge people higher prices; that is inflation. But it seems there is an exception. The higher price of government is deflation.

Along with his plea to coal operators, Mr. Truman said he hoped that steel men would not raise prices. The price of steel is about 33 per cent above its pre-war figure. Lately the steel men have raised the wages of their own employees by a sizable amount without raising their prices. Now their coal is to cost more but again they are put under pressure not to raise prices.

The cost of government is already several hundred per cent above pre-war. But the very people who are managing government and who in the main are resisting any cuts in the price of government are now advising the steel men and the coal men that they must not increase their prices.

And see how the law of supply and demand is working. People want more steel and things made of steel and they want all the coal that can be mined. But there is no doubt in the world that they want less government.

. . . Editorial, *Wall Street* Journal, July 15, 1947

RHODE ISLAND CASH SICKNESS COMPENSATION

Medical Statistics . . . Benefit Year 1944-1945

Prepared by Hendry C. White, technical assistant to the Rhode Island Unemployment Compensation Board

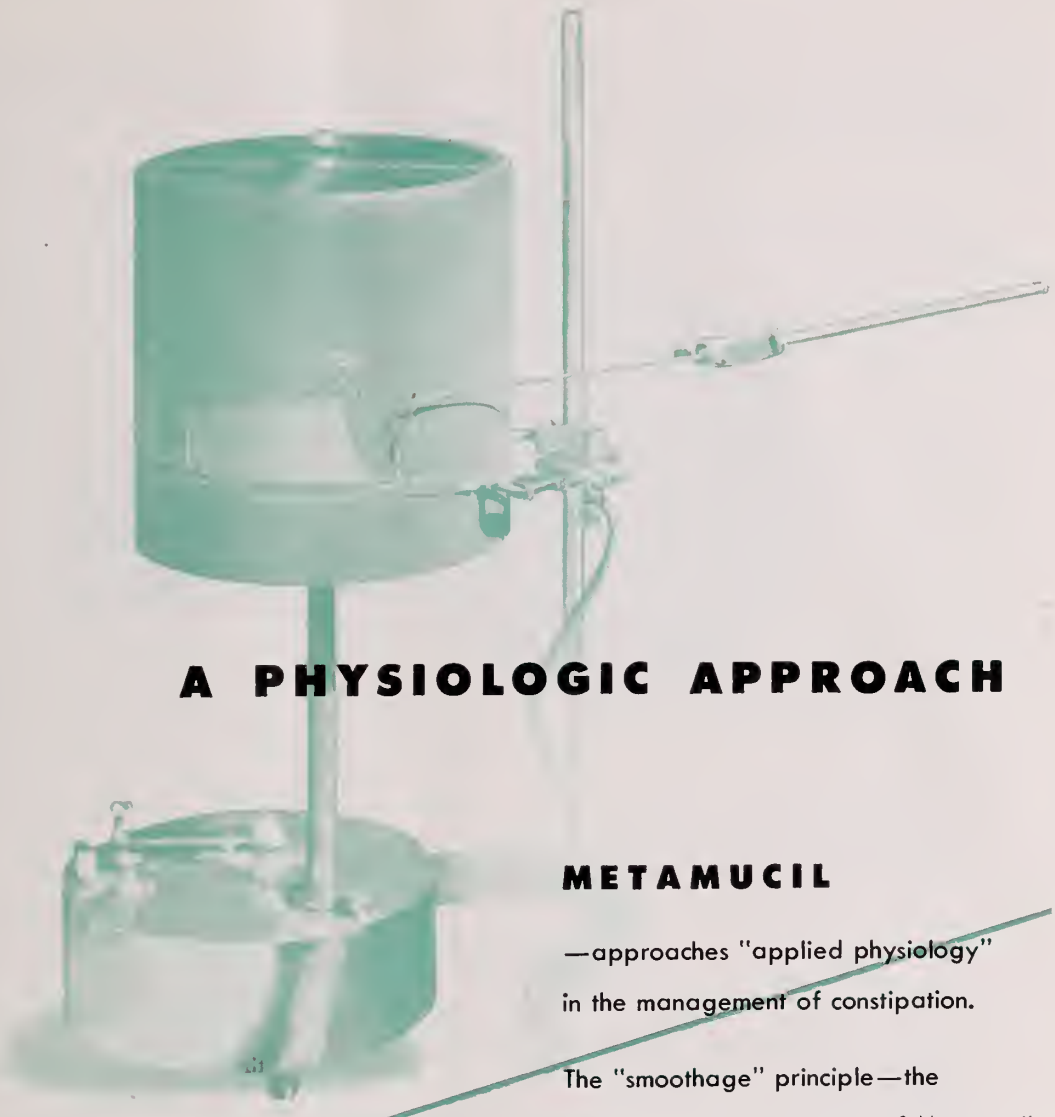
TABLE 1

Distribution of Benefit Payments By Diagnostic Groups

MALES (All Ages)—Benefit Year 1944-1945

	No. of Cases
I. INFECTIOUS AND PARASITIC DISEASES	
Typhoid fever and dysentery	4
Common communicable diseases of childhood	29
Tuberculosis of the respiratory system	226
Other forms of tuberculosis	13
Syphilis	31
Other infectious and parasitic diseases	105
II. NEOPLASMS	
Malignant neoplasm of the buccal cavity and pharynx	11
Malignant neoplasm of the digestive organs	35
Malignant neoplasm of the respiratory system	8
Malignant neoplasm of the male genital organs	7
Other malignant neoplasm	33
Other nonmalignant neoplasms	192
III. RHEUMATIC FEVER, DISEASES OF THE ENDOCRINE GLANDS AND NUTRITION, AND OTHER GENERAL DISEASES	
Rheumatic fever	76
Diabetes mellitus	95
Goiter	26
Other diseases of the endocrine glands	7
Other nutritional and general diseases	15
IV. DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS	
Anemia	83
Other diseases of the blood and blood-forming organs	5
V. CHRONIC POISONING AND INTOXICATION	
Chronic poisoning and intoxication	9
VI. DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS, INCLUDING MENTAL DISORDERS	
Inflammatory diseases of the central nervous system	14
Intracranial lesions of vascular origin	190
Other diseases of the central nervous system	76
Diseases of the cranial, sympathetic, and peripheral nerves	238
Psychoses	52
Other mental and nervous diseases	299
Diseases of the organs of vision	222
Diseases of the ear and mastoid process	48
VII. DISEASES OF THE CIRCULATORY SYSTEM	
Rheumatic heart disease, inactive	69
Hypertensive cardiovascular disease	178
Other diseases of the heart	1030
Hypertensive vascular disease	269
Other diseases of the arteries	126
Varicose veins and hemorrhoids	384
Other diseases of the circulatory system	172
VIII. DISEASES OF THE RESPIRATORY SYSTEM	
Influenza	390
Acute nasopharyngitis (common cold)	44
Tonsillitis with tonsillectomy	50
Diseases of the pharynx and larynx	164
Bronchitis	504
Pneumonia (all forms)	542
Other diseases of the respiratory system	481
IX. DISEASES OF THE DIGESTIVE SYSTEM	
Diseases of the buccal cavity and esophagus	34
Ulcer of the stomach and intestines	520
Diarrhea and enteritis	145
Appendicitis	344
Hernia	1014
Functional digestive disturbances	16
Other diseases of the stomach and intestines	198
Diseases of the liver and gall-bladder	225
Other diseases of the digestive system	14
X. DISEASES OF THE GENITO-URINARY SYSTEM	
Nephritis	61
Other diseases of the kidneys and ureters	124
Other diseases of the urinary system	48
Diseases of the prostate	119
Other diseases of the male genital organs	84
XII. DISEASES OF THE SKIN	
Diseases of the skin	574
XIII. DISEASES OF THE BONES AND ORGANS OF MOVEMENT	
Arthritis	524
Other diseases of the bones and joints	417
Other diseases of the organs of movement	101
XIV. CONGENITAL MALFORMATIONS	
Congenital Malformations	11
XVI. OTHER AND ILL-DEFINED DISEASES	
Ill-defined diseases	695
All other diseases	61
XVII. INJURIES AND POISONINGS	
Acute poisoning	14
Injury by foreign body and general effects of external causes, including concussion	108
Compound fracture	134
Simple fracture	1372
Dislocation, sprain, or other joint injury without fracture	1068
Burn or scald	172
Cut, laceration, or puncture wound	385
Abrasion, contusion, or other superficial injury	343
Other or unspecified injury	1553
TOTAL	17,029

continued on page 598



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RESEARCH IN THE SERVICE OF MEDICINE

CASH SICKNESS STATISTICS

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TABLE 2

Distribution of Benefit Payments By Diagnostic Groups MARRIED FEMALES (All ages)—Benefit Year 1944-1945

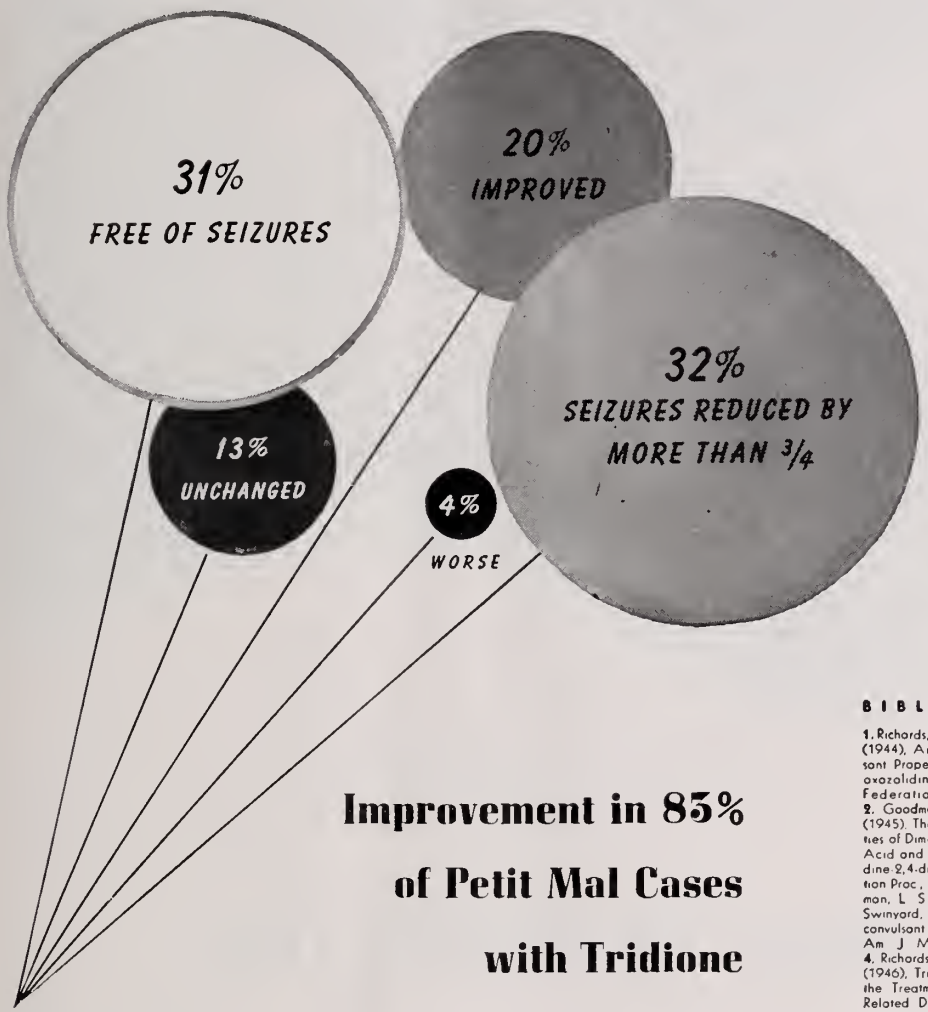
	No. of Cases
I. INFECTIOUS AND PARASITIC DISEASES	
Typhoid fever and dysentery	3
Common communicable diseases of childhood	12
Tuberculosis of the respiratory system	46
Other forms of tuberculosis	3
Gonococcus infection	1
Syphilis	4
Other infectious and parasitic diseases	50
II. NEOPLASMS	
Malignant neoplasm of the buccal cavity and pharynx	2
Malignant neoplasm of the digestive organs	4
Malignant neoplasm of the respiratory system	1
Malignant neoplasm of the female genital organs and breast	20
Other malignant neoplasm	14
Nonmalignant neoplasm of the female genital organs and breast	238
Other nonmalignant neoplasms	83
III. RHEUMATIC FEVER, DISEASES OF THE ENDOCRINE GLANDS AND NUTRITION, AND OTHER GENERAL DISEASES	
Rheumatic fever	51
Diabetes mellitus	108
Goiter	88
Other diseases of the endocrine glands	37
Other nutritional and general diseases	14
IV. DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS	
Anemia	267
Other diseases of the blood and blood-forming organs	2
V. CHRONIC POISONING AND INTOXICATION	
Chronic poisoning and intoxication	1
VI. DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS, INCLUDING MENTAL DISORDERS	
Inflammatory diseases of the central nervous system	4
Intracranial lesions of vascular origin	26
Other diseases of the central nervous system	12
Diseases of the cranial, sympathetic, and peripheral nerves	169
Psychoses	19
Other mental and nervous diseases	608
Diseases of the organs of vision	75
Diseases of the ear and mastoid process	45
VII. DISEASES OF THE CIRCULATORY SYSTEM	
Rheumatic heart disease, inactive	36
Hypertensive cardiovascular disease	134
Other diseases of the heart	400
Hypertensive vascular disease	380
Other diseases of the arteries	19
Varicose veins and hemorrhoids	263
Other diseases of the circulatory system	229
VIII. DISEASES OF THE RESPIRATORY SYSTEM	
Influenza	250
Acute nasopharyngitis (common cold)	48
Tonsillitis with tonsillectomy	47
Diseases of the pharynx and larynx	124
Bronchitis	296
Pneumonia (all forms)	132
Other diseases of the respiratory system	275
IX. DISEASES OF THE DIGESTIVE SYSTEM	
Diseases of the buccal cavity and esophagus	45
Ulcer of the stomach and intestines	94
Diarrhea and enteritis	102
Appendicitis	268
Hernia	69
Functional digestive disturbances	18
Other diseases of the stomach and intestines	94
Diseases of the liver and gallbladder	265
Other diseases of the digestive system	19
X. DISEASES OF THE GENITO-URINARY SYSTEM	
Nephritis	50
Other diseases of the kidneys and ureters	94
Other diseases of the urinary system	61
Diseases of the female genital organs and breast	1210
XI. DELIVERIES AND COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM	
Deliveries and complications of pregnancy, childbirth, and the puerperium	4907
XII. DISEASES OF THE SKIN	
Diseases of the skin	302
XIII. DISEASES OF THE BONES AND ORGANS OF MOVEMENT	
Arthritis	508
Other diseases of the bones and joints	173
Other diseases of the organs of movement	48
XIV. CONGENITAL MALFORMATIONS	
Congenital malformations	5
XVI. OTHER AND ILL-DEFINED DISEASES	
Ill-defined diseases	930
All other diseases	67
XVII. INJURIES AND POISONINGS	
Acute poisoning	4
Injury by foreign body and general effects of external causes, including concussion	30
Compound fracture	18
Simple fracture	287
Dislocation, sprain, or other joint injury without fracture	365
Burn or scald	39
Cut, laceration, or puncture wound	94
Abrasion, contusion, or other superficial injury	99
Other or unspecified injury	438
TOTAL	15,343

TABLE 3

Distribution of Benefit Payments By Diagnostic Groups OTHER FEMALES (All ages)—Benefit Year 1944-1945

I. INFECTIOUS AND PARASITIC DISEASES	
Typhoid fever and dysentery	2
Common communicable of childhood	25
Tuberculosis of the respiratory system	51
Other forms of tuberculosis	3
Malaria	2
Syphilis	2
Other infectious and parasitic diseases	31
II. NEOPLASMS	
Malignant neoplasm of the buccal cavity and pharynx	2
Malignant neoplasm of the digestive organs	5
Malignant neoplasm of the respiratory system	2
Malignant neoplasm of the female genital organs and breast	12
Other malignant neoplasm	4
Nonmalignant neoplasm of the female genital organs and breast	80
Other nonmalignant neoplasms	62

Continued on Page 601



Improvement in 83% of Petit Mal Cases with Tridione

Here's new evidence that Trldione is effective in petit mal. A recent study showed that it brought decided improvement in 83% of the patients to whom it was administered.[13] In this study, Tridione was given to 166 patients suffering from petit mal (pykno-epilepsy), myoclonic jerks or akinetic seizures. This group, as a whole, had received *little or no benefit from other medicaments.* With Tridione, 31% became free of seizures; 32% had fewer than one-fourth of the previous number of seizures; 20% improved to a lesser extent; 13% remained unchanged, and only 4% became worse. *Thus 83% showed improvement.* ● Furthermore, in some cases the seizures *did not return* when Tridione was discontinued. Studies also showed that Tridione was beneficial in certain psychomotor cases when given in conjunction with other antiepileptic drugs.[12] Prescription pharmacies everywhere stock Tridione in 0.3-Gm. capsules or in pleasant-tasting aqueous solution containing 0.15 Gm. per fluidrachm. May we send latest Tridione literature?

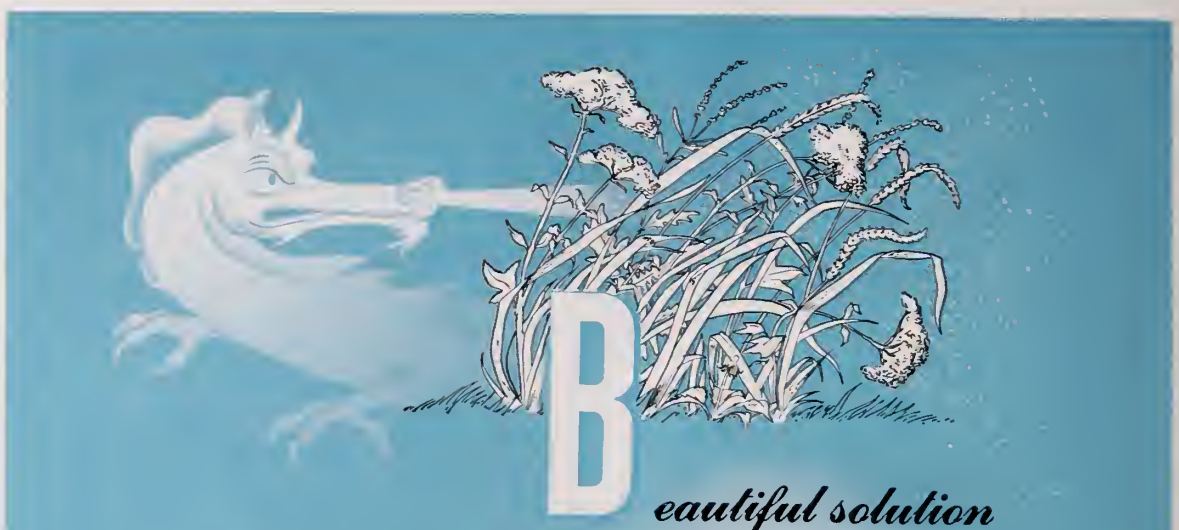
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CASH SICKNESS STATISTICS

continued from page 598

	No. of Cases
III. RHEUMATIC FEVER, DISEASES OF THE ENDOCRINE GLANDS AND NUTRITION, AND OTHER GENERAL DISEASES	
Rheumatic fever	56
Diabetes mellitus	28
Goiter	51
Other diseases of the endocrine glands	19
Other nutritional and general diseases	7
IV. DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS	
Anemia	138
Other diseases of the blood and blood-forming organs	1
V. CHRONIC POISONING AND INTOXICATION	
Chronic poisoning and intoxication	2
VI. DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS, INCLUDING MENTAL DISORDERS	
Inflammatory diseases of the central nervous system	3
Intracranial lesions of vascular origin	10
Other diseases of the central nervous system	16
Diseases of the cranial, sympathetic, and peripheral nerves	59
Psychoses	19
Other mental and nervous diseases	307
Diseases of the organs of vision	64
Diseases of the ear and mastoid process	30
VII. DISEASES OF THE CIRCULATORY SYSTEM	
Rheumatic heart disease, inactive	27
Hypertensive cardiovascular disease	51
Other diseases of the heart	147
Hypertensive vascular disease	98
Other diseases of the arteries	13
Varicose veins and hemorrhoids	74
Other diseases of the circulatory system	84
VIII. DISEASES OF THE RESPIRATORY SYSTEM	
Influenza	168
Acute nasopharyngitis (common cold)	30
Tonsillitis with tonsillectomy	70
Diseases of the pharynx and larynx	116
Bronchitis	166
Pneumonia (all forms)	86
Other diseases of the respiratory system	168
IX. DISEASES OF THE DIGESTIVE SYSTEM	
Diseases of the buccal cavity and esophagus	20
Ulcer of the stomach and intestines	34
Diarrhea and enteritis	67
Appendicitis	456
Hernia	26
Functional digestive disturbances	3
Other diseases of the stomach and intestines	53
Diseases of the liver and gallbladder	68
Other diseases of the digestive system	12
X. DISEASES OF THE GENITO-URINARY SYSTEM	
Nephritis	24
Other diseases of the kidneys and ureters	34
Other diseases of the urinary system	21
Diseases of the female genital organs and breast	258
XI. DELIVERIES AND COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM	
Delivery with live or stillbirth	131
XII. DISEASES OF THE SKIN	
Diseases of the skin	171
XIII. DISEASES OF THE BONES AND ORGANS OF MOVEMENT	
Arthritis	156
Other diseases of the bones and joints	74
Other diseases of the organs of movement	38
XIV. CONGENITAL MALFORMATIONS	
Congenital malformations	8
XVI. OTHER AND ILL-DEFINED DISEASES	
Ill-defined diseases	436
All other diseases	20
XVII. INJURIES AND POISONINGS	
Acute poisoning	3
Injury by foreign body and general effects of external causes, including concussion	28
Compound fracture	16
Simple fracture	232
Dislocation, sprain, or other joint injury without fracture	169
Burn or scald	27
Cut, laceration, or puncture wound	62
Abrasion, contusion, or other superficial injury	58
Other or unspecified injury	205
TOTAL	5,301

PSYCHIATRIC LESSONS LEARNED IN THE ARMY

concluded from page 586

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THE THIRD NEW ENGLAND INSTITUTE FOR HOSPITAL ADMINISTRATORS

The Third New England Institute for Hospital Administrators was held at Brown University, June 19 through 28th. There were 68 registrants from 12 states, including a representative of the Naval Hospital in Newport and Veterans' Administration hospitals.

These Institutes have been carried on at the University of Chicago for 14 years and the previous two in New England were held just prior to the war at Harvard Medical School. The student body indicated that the third New England Institute was one of the outstanding ones in their experience, due to the excellent faculty both from Brown University and the hospital field.

The Institute was designed for administrators and assistant administrators of hospitals, and as the majority are from hospitals of under 100 beds without schools of nursing and without interne training programs the scope of the Institute was naturally designed to meet the particular needs.

The general plan for the Institute included field trips, demonstrations and seminar sessions. The resources of Brown University and its community made possible an innovation in the nature of brief luncheon presentations on liberal art subjects.

The curriculum content was divided into six major divisions. "Human Relations" was one of the lead subjects with participation by experts Prof. Philip Taft of Brown University, Prof. Paul Pigors of Massachusetts Institute of Technology, and Mrs. Ann Saunders, Personnel Specialist of the American Hospital Association. Professor Taft provided a foundation for thinking on this subject by discussing labor and the present day world, and the impact on the hospital of the changes in labor relations. This was followed by Professor Pigors who outlined the importance of supervisors to a successful organization and stressed the importance of their training and their need for a comprehensive understanding of the thinking of top management. Mrs. Saunders tied this material in to the administrator of a hospital and his responsibility in this respect as a prerequisite to a successful and well-ordered hospital.

The medical staff of a hospital, the backbone of modern hospital service, came in for some major attention with Dr. Francis J. Bean and Dr. Alex M. Burgess discussing organization. Dr. Charles Wilkinson of the University of Michigan interpreted the medical staff development and interne and resident training in relation to a hospital system which is primarily work eminating from the University of Michigan Medical School and Hospitals. Dr. Frederick T. Hill carried two important medical staff subjects—first, "Group Medical Practice", and "Medical Staff Audit", pointing out not only the mechanics involved and the value in present day care of the patient but the need for comprehensive understanding and control of medical practice within the hospital.

Organization and management was discussed by leaders from the faculty of Brown University, Harvard School of Business and from the hospital field, all stressing the need for fundamental organization to modern and satisfactory hospital practice.

The importance of close co-ordination between public health development and hospital development and the need for a broad concept of hospital service on the part of the administrator was brought out by such able leaders as Dr. Ira V. Hiscock, Professor of Public Health at Yale University, Dr. Charles F. Wilinsky, Director of Beth Israel Hospital, and Reverend Donald A. McGowan, Director of Catholic Hospitals, Boston.

The hospital of tomorrow envisioned as a much greater public service enterprise than was the original concept when many of our voluntary hospitals were founded was very adequately handled by Dr. Charles A. McDonald of Brown University, Dr. Nathaniel W. Faxon of the Massachusetts General Hospital, Mr. James A. Hamilton and Dr. Frank R. Bradley both professors of Hospital Administration at Minnesota and Washington Univerties respectively.

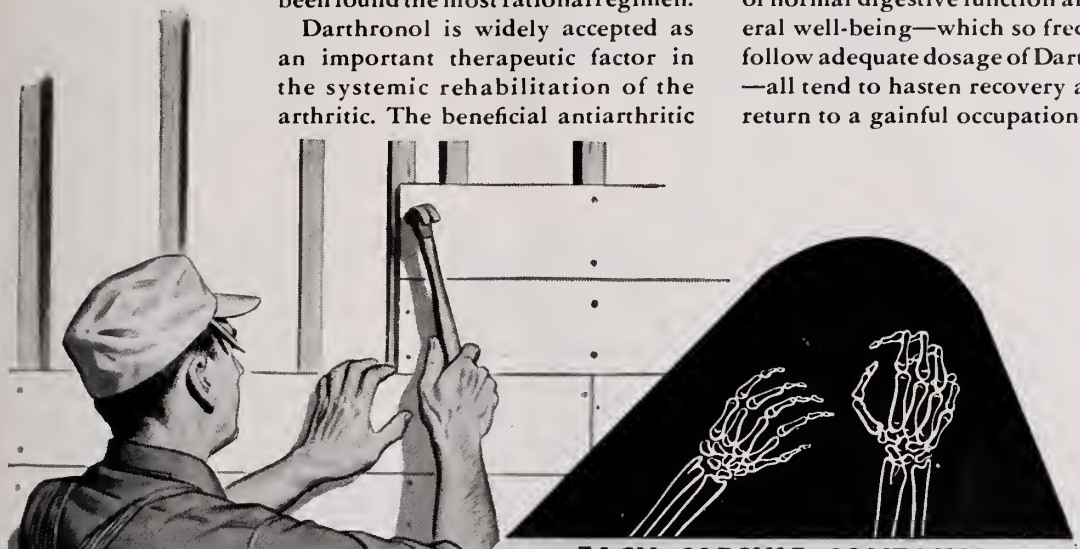
Each lecture contributed greatly to the thinking and particular aspect of hospital management and yet the entire emphasis for the entire Institute and of each lecturer was focused on the fundamental reason for hospitals—the care of the individual patient.

SYSTEMIC REHABILITATION

Gainful occupation restored

For long-lasting alleviation of pain and restoration of function in arthritic patients, systemic rehabilitation has been found the most rational regimen.

Darthronol is widely accepted as an important therapeutic factor in the systemic rehabilitation of the arthritic. The beneficial antiarthritic effects of the contained massive dosage of vitamin D, the improvement of appetite, decrease of pain, restoration of normal digestive function and general well-being—which so frequently follow adequate dosage of Darthronol—all tend to hasten recovery and the return to a gainful occupation.



EACH CAPSULE CONTAINS:

Vitamin D (Irradiated Ergosterol)	50,000 U.S.P. Units
Vitamin A (Fish-Liver Oil)	5,000 U.S.P. Units
Ascorbic Acid	75 mg.
Thiamine Hydrochloride	3 mg.
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Mixed Tocopherols	4 mg.

(Equivalent to 3 mg. of synthetic Alpha Tocopherol)

A **ROERIG** *Preparation*



For the Arthritic

DARTHRONOL

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WOMAN'S AUXILIARY

Mrs. Herbert E. Harris, President of the Woman's Auxiliary announces the following committee appointments:

Organization Committee

Mrs. Bertram H. Buxton, *Chairman*
Mrs. James C. Callahan
Mrs. Louis C. Cerrito
Mrs. H. Lorenzo Emidy
Mrs. Joseph C. Kent
Mrs. Earl Mara
Mrs. H. Frederick Stephens

Editorial Committee

Mrs. J. Lincoln Turner, *Chairman*
Mrs. Charles L. Farrell
Mrs. Francis L. Burns

Program Committee

Mrs. Charles F. Gormly, *Chairman*
Mrs. Thomas S. Flynn
Mrs. Martin O. Grimes
Mrs. Joseph K. Harrop
Mrs. Joseph C. Johnston
Mrs. William J. Johnson
Mrs. H. Frederick Stephens
Mrs. Harry Triedman

Revision Committee

Mrs. Henry S. Joyce, *Chairman*
Mrs. Stanley D. Davies
Mrs. Charles L. Farrell
Mrs. Arcadie Giura
Mrs. William N. Hughes

Legislative Committee

Mrs. Herman A. Lawson, *Chairman*
(Remainder of Committee to be announced later)

Public Relations Committee

Mrs. James P. O'Brien, *Chairman*
(Remainder of the Committee to be announced later)

Historian

Mrs. Joseph C. Johnston

OCTOBER MEETING PLANNED

Present plans call for a meeting of the Auxiliary to be held at the Rhode Island Medical Library in October. The date has been tentatively set as Monday, October 27, and an all day meeting is contemplated. The morning session would be concerned with organizational work of the Auxiliary, and the afternoon meeting would be open to the general public for a discussion of some pertinent public health problem. Complete details will be announced early in the Fall.

MEMBERSHIP ROSTER

The Auxiliary membership roster now numbers approximately 200. The wife of any physician who is a Fellow of the Rhode Island Medical Society is eligible for membership, and applications together with annual membership dues in the amount of $3.00 should be made to Mrs. Charles L. Farrell, secretary, or Mrs. Jesse P. Eddy, 3rd, treasurer.

for vaginal douches, colonic irrigations, and rectal enemas...

Irrigol

. . . An alkaline, saline powder that makes an aseptic, and slightly astringent solution. Excellent clinical record. For facts folder and sample, write The Alkalol Company, Taunton 12, Mass.



Producers of Ethically Promated Alkalol Since 1896



The "sense of well-being" so frequently reported by patients following "Premarin" therapy often means the difference between an active, enjoyable middle age and a sedentary one. Not only prompt relief from distressing menopausal symptoms but also a brighter mental outlook which may be translated into a desire "to be doing things"...such are the results which may usually be expected following "Premarin" administration . . . therapy with a "plus."

"Premarin" provides effective estrogenic therapy through the oral route with comparative freedom from untoward side effects.

"Premarin" is available as follows:

Tablets of 2.5 mg.....bottles of 20 and 100.
Tablets of 1.25 mg.....bottles of 20, 100 and 1000.
Tablets of 0.625 mg.....bottles of 100 and 1000.
Liquid, containing 0.625 mg. in each 4 cc. (1 teaspoonful).....bottles of 120 cc.

While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens . . . estradiol, equilin, equilenin, hippulin . . . are also present as water-soluble sulfates. The water solubility of conjugated estrogens (equine) assures rapid absorptian from the gastrointestinal tract.

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PURPOSES OF A STATE MEDICAL JOURNAL*

JOHN E. FARRELL

(Executive Secretary, Rhode Island Medical Society, and
Managing Editor, Rhode Island Medical Journal)

A STATE MEDICAL JOURNAL, as the official printed organ of a state medical society, may be considered to have as its primary purpose the presentation of the news and views of the medical profession in that state, both to the physicians and to the public generally. Thus, the state medical journal may be recognized as the newspaper of the local medical profession.

With that thought in mind I have amended my favorite definition of a newspaper to fit the medical journal, and I offer this definition:

> A state medical journal is a business of creating and focusing professional and public attention by means of the periodical publication by printing, of information concerning recent, current or prospective events concerning medicine and public health; of interpretation of and comment upon such events; of entertaining and instructive matter not necessarily dealing with current happenings; and of selling as advertising space the attention and interest thus attracted and focussed.

That the publication of a state medical journal is a business demanding the time, energy and ability of its guiding staff any editor or managing editor will attest. That many of our state medical journals, including the one with which I have a direct responsibility, fall far short of what constitutes real journalism is readily admitted. Therefore, in the observations that follow the intention is to observe what would, in my opinion, constitute some of the qualities of an excellent state medical journal, thereby fulfilling adequately any stated or understood purposes of that type of a publication.

The state medical journal is not intended, nor utilized, to present original scientific clinical discoveries. Undoubtedly there was a day when the journals were so used, but with the creation of national and specialty journals, and with the printing of research studies by foundations and other organizations, the role of the state journal has been that of reflection of local thinking and findings. Through the medium of the annual state scientific assembly some clinical papers are available from national or regional authorities, but for the most part the state journal must rely upon home talent for articles. And that is as it should be, for the purpose of the book is to bring the local profession up to date on local work.

The state journal should seek to present short, current medical papers, tinged by the personality of the author. To be of real interest such articles must be timely, to the point, and headed by as brief and informative title as possible. Unfortunately most of our journals for one reason or other violate all these conditions. We depend upon a backlog of papers accruing from our annual meeting, and often we disregard the timing of our releases according to the season of the year in which they are published. We often fail in editing, allowing the author to take a running start that frequently outlasts the patience of the reader. Or again, we allow the contributor to inflict upon us a double column heading of great length that either confuses the would-be reader, or sends him hastily to other pages of the book.

One important source of clinical material for state medical journals that has a good reader interest is that of clinicopathological conferences at leading hospitals. The New England Journal of Medicine has set a pattern in this respect, and many of the state journals have emulated it to advantage. We have adopted this idea in Rhode Island and our Journal has accepted the expense of verbatim stenotype reporting of some of the bi-monthly conferences at Rhode Island Hospital. They have proved most informative.

As a chronicler the state medical journal should open its pages to the reporting of state and community programs, both public and private, that involve medical care or public health. There are many organizations allied to the medical profession that attract fine speakers to their meetings whose addresses, while directed for the most part to a lay audience, are worthwhile reading for the physician if he is to have a broad viewpoint of the public interest and participation in the work to which he has devoted his life. And in the acceptance of some manuscripts the Journal must assume the role of the newspaper by reporting both sides of a controversy, and not always maintain a biased or one-sided view. I am mindful in this connection of the action of our Journal a year ago in reporting in full, with the lead pages facing, the addresses of your Dr. Joseph Howard and of Mr.

* Presented at the Semi-Annual Conference of County Medical Association Presidents and Secretaries of the Connecticut State Medical Society, New Haven, March 20, 1947

Arthur J. Altmeyer, Chairman of the Federal Social Security Board, on the question of voluntary versus government health care.

The Editorial Function

The citing of this example of reporting a controversy brings me to what I consider the most important, and the most neglected, purpose of a state medical journal. The editorial is the heart of the journal, but it does not beat very loudly in most states, and it takes its place as the number one malady of our publications.

Our scientific and clinical presentations are necessarily directed to the physicians in our immediate areas. Our editorials must assume a broader role—that of interpreting what has happened in the realm of medicine and public health, both locally and nationally, of explaining the relations of one thing to another, and their functions. Our editorials must reflect the opinions and the decisions of the medical profession in our states, and they must speak not alone to the membership of our societies, but to the general public. We must follow the precept of Joseph Pulitzer and talk to a nation, not to a select committee.

A good editorial department will make a journal live. It will exert force upon the opinions of the people in matters of vital importance regarding their health. The editorial must not reflect the viewpoint of the editor; it must represent objectively the thinking of the Society as seen through the eyes of a well-informed editorial staff. We should allot no space for narrow-minded opinions, nor should we be prejudiced unduly against all who disagree with our opinions.

But when we know that we are being attacked, or when we see anywhere the threat to the profession or to the medical care of the people, we cannot be militant enough. Too often do the state journals become verbose in editorials without pointing definitely and with finality to what is wrong, why it is wrong, and why the medical profession challenges the evil as it sees it. In my opinion our Journals too often hesitate to enter public controversies because the attending publicity is considered unfavorable, even though the cause is just.

We are not alone facing this problem. As Sevellon Brown, Editor and Publisher of the Providence Journal-Bulletin, pointed out recently at the seminar for editorial writers of the American Press Institute, ". . . candor compels the confession that today, far, far too many publishers are not giving their editorial staffs the support they need for the task of producing a reflective page of opinion upon so complex and bewildering a social and political scene . . . our editorial staffs are undermanned and opportunity for study, contact and reflection for editorial writers is far too meager. A quantity of production utterly irreconcilable with quality is required as a daily routine. The result—words, words, word."

State medical journals may well heed this thinking. When valuable space is given month after month to so-called editorials that consist of reprints from AMA or press news releases, programs of annual or other meetings with no comment thereon, etc., then truly the editorial function is submerged by the news function. Undoubtedly in many states the editorial work is left to one or two men. Certainly it would appear that little conference study has gone into some of the editorial pages I have read in recent months. A well chosen staff picked for ability to interpret medical and health problems, particularly on the local level, and meeting monthly in conference to shape the editorial policies is, in my opinion, the major solution to the problem.

News Departments

The various news departments of the state medical journals vary according to local tastes, but for the most part they are fairly well organized, thus bespeaking the desire to satisfy the orderly thinking of the physician-reader. There are a few ob-

continued on next page



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FOR ABDOMEN, BACK AND BREASTS

PURPOSES OF A STATE MEDICAL JOURNAL

continued from page 607

servations, however, that I would make. Some journals give good coverage to meetings of the state society, but are not as solicitous of the district society meetings. Perhaps this situation is due in measure to the fact that the district societies are not organized to report as promptly of their meetings. But this is all the more reason why the state journal editorial staff should be alert to reach the county secretary by telephone, or mail, the day after his meeting to seek timely reports advantageous both to the success of the journal and to the satisfaction of the membership involved.

Many large states seek county society news through press clipping services. That is undoubtedly the ideal way to get accurate, prompt and complete coverage, for those not utilizing such service the task is an endless one of reaching the county secretary. The answer would appear to be to seek an editorial correspondent in each county upon whom the journal may rely for prompt filing of local news, as well as the reporting of major local problems worthy of editorial study and interpretation.

One criticism that I have of many state journals is their indiscriminate use of what we call "fillers." These are items sent as press releases by scores of national, sectional, and local agencies. Some journals make no effort to edit such copy, printing it verbatim, utilizing valuable space to tell in many words a message that has appeal to a very limited number of the membership. Several journals have done outstanding jobs in correlating all such news into a section. In Rhode Island we run, as occasion demands, a section titled "Through the Microscope" whereby we attempt to edit the highlights of scores of releases and news items culled from other bulletins and journals. We make brief statements that make for easy, and we hope, interesting reading.

Of paramount importance in the departments is the necessity for the reporting of local news. Most of our membership subscribes to one or more national medical publications and therefore has information on national issues. What they want in our state journal is state news stories, and what the state medical society contemplates on the local level to meet both local and national problems.

The Role of Advertising

Advertising in state medical journals has been treated, until recent years, as a liability rather than as an asset. Many journals have accepted advertisements to secure financial returns to support the publication, and then loaded the displays in the back of their books. Advertisers, faced with the necessity of reaching the physician through the

continued on page 610

specific

for
gram-positive
localized
infections!

Administered by instillation, irrigation, wet dressing or spray, TYROTHRICIN, Sharp & Dohme, is rapidly bactericidal and sparingly absorbed, penetrating minute tissue crevices of the infected area. Moreover, it is relatively stable and possesses very low toxicity when applied topically. • TYROTHRICIN is remarkably effective in treatment of superficial indolent ulcers, abscesses of the skin and soft tissues, chronic purulent otitis media, mastoiditis, sinusitis, empyema and certain types of wound infections. • TYROTHRICIN CONCENTRATE (*For Human Use*), Sharp & Dohme, is supplied as follows: Package containing 1-cc. ampul of a concentrated solution of TYROTHRICIN, 25 mg. per cc., with vial containing 49 cc. of sterile, distilled water for diluting the concentrate before use; also supplied in 10-cc. and 20-cc. vials of a concentrated solution of TYROTHRICIN, containing 25 mg. of the antibiotic per cc. Sharp & Dohme, Philadelphia 1, Pa.

TYROTHRICIN

Concentrate

SHARP & DOHME

PURPOSES OF A STATE MEDICAL JOURNAL

continued from page 608

professional journals accepted the space offered and optimistically hoped that the journal would prove sufficiently interesting to its readers to attract them to the display ad section.

In recent years the situation has changed decidedly. For one thing the journals have recognized that most of the advertising displays were decidedly informative, colorful, and in many instances more interesting and timely than some of the news copy submitted to the readers. The trend spread to bring the displays out of the seclusion of the rear of the book, and to grant them a fair opportunity to capture the attention of the physician.

The advertisers for their part have begun to realize that the state medical journal is their best salesman. They have begun to realize that state journals are read widely in local areas, for the axiom that the value of news depends largely on the familiarity of the reader with the locality in which the event happens, and with the persons, places, things and circumstances involved in it, holds equally true for the state medical journal as it does for the daily newspaper. Our state medical journals include articles by local physicians, news of local physicians and local events and interpretations of local problems as well as national issues affecting the local medical profession. Thus our state journals when well edited have a far greater reader interest than the national or sectional journal can ever have, in our individual states.

Advertising in the state medical journal is directed to the profession, not the general public. The bulk of it comes from reputable advertising agencies representing outstanding pharmaceutical companies, and copy is carefully written and edited to prevent the publication of unwarranted claims. With the tightening of the national Food and Drug Law there is little opportunity for false advertising in any publication, but the mere fact that a product is advertised in a state medical journal in no manner implies a recommendation of it. It is to be doubted that any physician draws such a conclusion. Even the Council on Pharmacy of the American Medical Association states that in admitting an article in the New and Non-official Remedies it does not imply any endorsement whatever of the product. There is an honest difference of opinion on many therapeutic questions, and it is natural that a manufacturer should be partial to his own product. The physician knows that and uses his own good sense accordingly.

There is need for wider exploration of ways to improve advertiser relationships with the journals. The present strong position should be cemented with advertising services by the journal for both the buyer and the consumer. In Rhode Island we have taken several such steps. Our latest has been the publication of a directory of the sales representatives of our advertisers detailing physicians in Rhode Island and Southeastern Massachusetts. This printed directory has been supplied to every physician in those areas for personal reference. It offers a fine service to the busy doctor, and an even greater one to the detail man servicing his needs.

The Pattern for the Future

The state medical journals are presently enjoying an enviable position. They have won substantial advertising support which has enabled them to improve their publications as regards format and news coverage. They have proved to many advertisers that the reader interest of the state journal is the greatest in the professional publication field.

With the engaging of full-time executive officers by many state societies the administrative and mechanical phases of the journals are in excellent hands. The future success, then, depends upon the work of the editorial staff.

Professional advice should be sought to improve the publications, and conferences such as the writer has advocated for the past four years should be held on a national or regional basis to permit a reflective study of the journals aimed towards their improvement. Editorial boards should meet regularly, should explore ways to improve their book, and most important, should make the editorial department a live, active voice in the shaping of local problems of whatever nature that affects health or medicine.

PATRONIZE
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ADVERTISERS

IN OLNEYVILLE IT'S . . .
McCAFFREY INC.
Druggists
19 OLNEYVILLE SQUARE
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"THE PURPOSE OF A MEDICAL JOURNAL"

Under this title John E. Farrell, Executive Secretary of the Rhode Island Medical Society, addressed the county society secretaries of Connecticut, recently. Mr. Farrell, one of the "live" secretaries, is well qualified to speak on this subject anl much that he had to say is worthy of note.

He compares medical journalism with lay journalism —they both have, or should have—the same objectives, that of furnishing to their readers reports of current and prospective events in their respective fields. He further observes that too many of our journals do not come up to the mark of *real* journalism and offers some suggestion for improvement.

He prefers, and in this we agree, that State Journals will do well to leave original scientific clinical discoveries with the national and specialty publications. "The State Journal should seek to present the short, current medical papers, tinged with the personality of the author." Again shall we have to agree with Mr. Farrell.

Again, he speaks of the "seasonableness" of the papers, a most important thing. Certain diseases seem to select certain seasons of the year for their activities and it is at this time that articles, written from personal experiences, will be best received by readers. He also favors our keeping in touch with many of the "health organizations," even though lay controlled; their annual meetings often provide interesting reading material for physicians.

Mr. Farrell criticizes the editorial department of many of our journals, most of them, in fact; says that while the editorial department is the heart of these journals, "it does not beat loudly in most states." Narrow-minded opinions and controversial matters should be avoided—we are speaking not only to our own membership but to the medical profession of America.

He believes we should be more militant, especially when attacked as we have been for several years past, too many words are used in talking about these things, too few in pointing out why this or that is wrong.

He then strikes a new note when he speaks of the reporting of medical meetings within one's state—too much attention is given to reports of the annual state meeting, too little of what goes on in the county societies. He strongly criticizes the all-too-frequent use of "fillers," these items being sent in by various agencies and too often not edited, but used "as is."

His address is of unusual interest to those concerned with the publication of our state journals and covers the field very nicely. However, we should like to make this comment—we do not believe that a single pattern can be set for all state medical journals to follow; there is too much variation throughout the states. What will be found of the greatest interest in one state will fall absolutely flat in another. Some states, for example—Indiana being a devout believer in the plan—have a regular news notes and personals department. Our readers like this, so they tell us—on the other hand it would fail to interest perhaps some other communities. We like to feel that our publication is, primarily, for Hoosier physicians; we have lived a long time among them and believe we know them.

* * *

. . . Editorial, *THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION*, July, 1947

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PRELIMINARY REPORT OF HEALTH DEPARTMENT STATISTICS

PROVIDENCE * RHODE ISLAND

1946

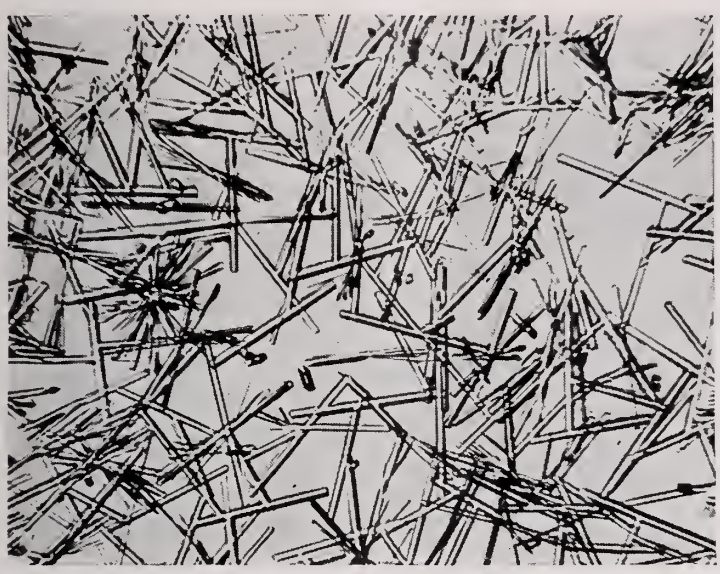
VITAL STATISTICS	1946	1945	1944
Deaths all	3173	3158	3268
Deaths under 1	269	227	275
Deaths over 70	1157	1120	1241
Births	10215	8232	8192
Marriages	3903	2814	2619
Infant Mortality	26.33	27.57	33.57
Death Rate	11.92	11.91	12.42
Birth Rate	38.40	31.06	31.14
PRINCIPAL CAUSES			
1. Heart Disease	1054	1082	1057
2. Cancer	484	446	451
3. Pneumonia	108	115	174
4. Nephritis	182	188	198
5. Cerebral Hemorrhage	216	224	247
6. Auto Accidents	49	41	28
LABORATORY EXAMINATIONS			
Chas. V. Chapin Hospital	33137	27888	27113
MILK DEPARTMENT			
No. Samples Tested	16873	22373	23621
No. Licenses Issued	1389	1329	1411
PHYSICIANS			
No. Visits to Sick Poor	986	1788	2266

	1946	1945	1944
DIPHTHERIA IMMUNIZATION			
No. Schick Tests	7217	7084	7900
No. Alum Toxoid Treat.	4394	4715	4199
SMALLPOX IMMUNIZATION			
No. Vaccinated	2208	2512	2871
INSPECTORS			
Food Inspector:			
Inspections	9041	8687	8133
Licenses Renewed	1917	1779	1650
New Licenses	210	92	100
Transfers	150	131	103
Licenses Withdrawn	0	1	0
Licenses Not Approved	5	0	2
Licenses Revoked	1	1	3
Sanitary Division:			
No. of Visits	6225	7524	6855
Animal Bite Visits	1461	1248	1270
Kennel Lic. Approved	36	78	80
Garbage Lic. Approved	12	21	20
NURSING VISITS			
Communicable Diseases	6288	4626	7114
Parochial Schools	4662	3200	5010
Tuberculosis — Home	7466	4958	4845

COMMUNICABLE DISEASES	CASES 1946 Res	CASES 1946 Non Res	CASES 1945 Res	CASES 1945 Non Res	*DEATHS* 1946 Res	*DEATHS* 1946 Non Res	*DEATHS* 1945 Res	*DEATHS* 1945 Non Res
Diphtheria	11	10	5	3	0	1	1	0
Scarlet Fever	186	56	256	60	0	0	0	0
Measles	1079	14	106	0	0	0	0	0
Whooping Cough	1097	26	994	25	2	1	2	2
Pulmonary Tuberculosis	180		390		51	8	55	14
Septic Sore Throat	1	0	5	0	0	0	0	0
Streptococcus Sore Throat	36	3	26	1	1	1	0	1
Gastro Enteritis	26	14	65	25	5	2	5	6
Bacillary Dysentery	7	0	30	9	0	0	0	0
Poliomyelitis	9	79	0	4	0	5	0	0
Epidemic Meningitis	12	17	17	17	3	4	2	1
Typhoid Fever	0	1	3	2	0	0	0	0
Paratyphoid Fever	3	3	6	1	0	0	0	0
Epidemic Encephalitis	0	0	1	4	0	0	0	1
Ophthalmia Neonatorum	0	0	1	1	0	0	0	0
Undulant Fever	1	2	1	0	0	0	0	0
Infectious Mononucleosis	4	1	4	3	0	0	0	0
Trichinosis	12	7	2	0	0	0	0	0
Tetanus	1	1	0	1	0	0	0	0

* Includes Non-Residents*

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SENATORIAL VIEWS ON HEALTH INSURANCE

SENATOR TAFT: We recognize that the Government has an obligation to give free service only to those people who are unable to pay for it themselves in full, directly or through voluntary health insurance. State medicine proposes that the Government tax everybody to the tune of about four or five billion dollars a year, and then give medical aid free to over one hundred million people. That is what socialism is. If free medical care for all at the expense of taxation, why not free food, clothing, housing for all at the expense of taxation?

SENATOR McGRATH: I believe that Senator Taft misconstrues the issue entirely. We are talking about health for the American people, not health for only those who are unable to pay for it.

SENATOR TAFT: Those who are able to pay for it can pay for it. My only insistence is that they do pay for it, not that the Government pay for it.

SENATOR McGRATH: The fact of the matter is that they are dying by the hundreds———

SENATOR TAFT: (Interposing): Nonsense, Senator McGrath!

SENATOR McGRATH: More deaths are occurring in the wealthy classes—that is, when I say the wealthy classes, I refer to the middle classes—than in the poorer classes.

SENATOR TAFT: And our death rate is steadily declining, owing to the excellent service given by a free medical profession in the United States.

SENATOR McGRATH: Our plan proposes that the doctors be paid for that service so that they don't have to give it free.

* * *

SENATOR TAFT: Compulsory insurance is not insurance at all; it is taxation. Insurance is the payment of something in return for taking care of a certain risk.

SENATOR McGRATH: For an anticipated risk.

SENATOR TAFT: This tax has no relation to that risk at all. A man with a $3600 income is going to have to pay $144, even though he has only himself and his wife. A fellow with a $1000 income pays $40 a year though he has a wife and six children. It is a principle of taxation.

SENATOR McGRATH: Senator, you are still using percentage figures that are beyond anything in the bill.

SENATOR TAFT: No, no, this will be a 4 per cent tax.

SENATOR McGRATH: But he is not paying the 4 per cent.

SENATOR TAFT: If that were so, why didn't you introduce a tax bill. It is easy to introduce a bill about spending money like this, but you have not introduced a tax bill providing the money.

SENATOR McGRATH: Your bill is a spending bill. Your bill proposed to appropriate $200,000,000, and we do not appropriate one cent from the treasury.

SENATOR TAFT: Your bill will cost $5,000,000,000, and you don't dare tell where you are going to get it. You don't dare introduce a tax bill that will take care of it.

SENATOR McGRATH: We are going to get it from the people of America who are begging for this kind of program, and dying for lack of it.

SENATOR TAFT: You are going to get it through a pay roll tax, I presume, but you don't introduce the pay roll tax bill; you don't bring that in and tell us about it. Presumably it is going to be a pay roll tax bill so that a man with $2500 income is going to have to pay $100 a year for medical service. He can go and get voluntary medical insurance for about $87 for a family of five in Michigan today.

* * *

. . . Abstracted from the *American Forum of the Air* radio discussion on "WHAT SHOULD CONGRESS DO ABOUT HEALTH INSURANCE", June 3, 1947



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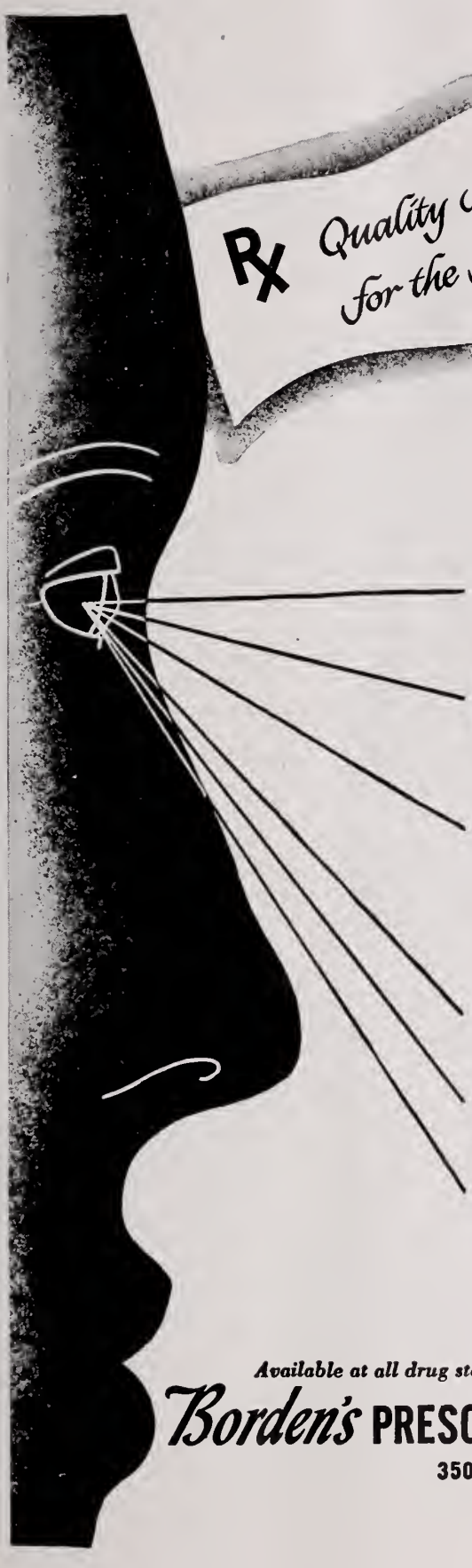
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THE NATIONAL BLOOD PROGRAM

of the

AMERICAN NATIONAL RED CROSS

On June 12, 1947, the new Board of Governors, American National Red Cross, meeting in Cleveland, Ohio, ratified and confirmed a previous action of the Central Committee approving and authorizing the National Blood Program as an activity of the American National Red Cross. By this decision they brought to a climax several years of intensive study and consideration of what the American National Red Cross might do to help supply blood needed to safeguard the health of all the people of the nation and to be the means of saving the lives of untold thousands.

THIS ACTION insures to peacetime the gains to humanity of the record in life saving that had never been equaled before in times of war. It recognizes that the lessons learned since the dropping of the atomic bombs on Hiroshima and Nagasaki call for broad national planning to meet the future needs of national defense, both military and civilian.

There are five important operations in connection with a national blood program:

(1) collecting the blood

(2) processing it for use as whole blood and blood derivatives, including packing and storage

(3) distributing the blood and blood products for the needs of the people

(4) making blood available for continuous research and investigation to insure safety of the products and to determine the uses to which they may be put for the greatest benefits of mankind

(5) maintaining of high standards set by the leading authorities in this field.

A program of such magnitude must of necessity be one of gradual development. Time will be required to organize the work, to procure and train the personnel, and to obtain equipment which is in short supply. The first year of operation contemplates the establishment of 20 or 25 centers carefully selected with relation to the advantages they offer in the early stages. It is estimated that from three to five years will be required before the program is in full operation. In the meantime local programs will continue on their present basis, and new programs will be established as heretofore with the expectation of integration with the national program later on. In this way, full benefits from the fractionation phase of the program will be available to those communities where only whole blood and plasma are now being provided.

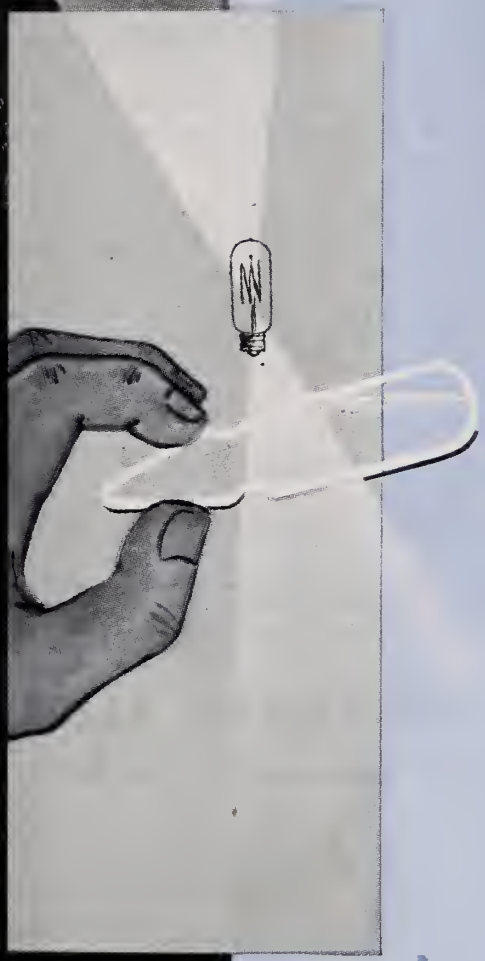
In addition to whole blood and plasma, the National Blood Program will provide other blood derivatives of proved value: serum albumin, used for shock and certain kidney diseases and other conditions; immune serum globulin, for modification or prevention of measles; antihemophilic globulin, effective in the treatment of hemophiliacs, or "bleeders", blood grouping serum, for determining blood types; fibrin films, used in brain and nerve surgery; red cell suspensions, for treating certain anemic conditions; and red cell paste and powder, to promote the healing of certain wounds. Any other products which continuing research may find useful in medicine and surgery will be provided.

Since people in rural districts require blood as well as those in cities the program must be sufficiently flexible to meet widely varying conditions and needs in large and small communities throughout the country. It is the ultimate goal to collect blood from volunteers from every community everywhere and to give every healthy person an opportunity to make a contribution at least once a year. For those people to whom a blood donor center is not available it is planned to provide the services of a mobile unit.

Under certain conditions it may be expedient to type the donors in a community and have them available when whole blood is needed in an emergency situation. In other instances plasma or serum albumin and other stable derivatives will be made available and will tide cases over until whole blood can be transported from a central depot where all types are constantly on hand. In this way the program will be enabled to fulfill its purpose to furnish blood, blood plasma, and all of its derivatives to all the people of this country irrespective of race, creed, color or financial ability to pay. The only charge ever made to any patient will be a reasonable one by the physician or hospital for professional services in administering the material. The Red Cross will make no charge.

continued on page 618

Hold it up to the Light!



A life may depend on the purity and clarity of the urographic contrast medium to be injected intravenously. NEO-IOPAX, a superior solution for intravenous pyelography, is triple checked through every stage of its preparation for exact composition and sterility, and then inspected repeatedly for the presence of extraneous foreign matter.

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Hold your contrast medium up to the light before injecting it. You will find NEO-IOPAX solutions sparkling and crystal clear—a good index of the care with which they have been processed. Naturally, we take pride in the NEO-IOPAX safety record, based on hundreds of thousands of injections.

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RED CROSS BLOOD PROGRAM

concluded from page 616

That part of the program which deals with collecting blood will operate substantially along the same lines as the wartime blood program, with established blood donor centers, and with mobile units to cover outlying communities. Red Cross chapters will assume the important responsibility of complete community organization to enroll blood donors and will arrange for the bleedings as needs require. In addition to the competent professional personnel for technical work, many volunteers will be necessary for nontechnical work in the centers.

That part of the program which deals with processing of the blood will involve highly skilled work. Some of the blood collected will be examined, typed, and distributed to local hospitals for use as whole blood; some of it will be shipped to commercial laboratories with which contracts will be made by national headquarters to fractionate blood into its derivatives. It is believed that approximately 60 percent of the blood collected will be used as whole blood.

That part of the program which deals with distribution involves making the best possible arrangements that will afford ready accessibility of the blood and blood products to all people and their physicians and hospitals, including veterans, military, and marine as well as civilian hospitals.

That part of the program which deals with continuous research and study as to the effectiveness and new uses of the blood products will be carried on by research authorities with the guidance of the Blood and Blood Derivatives Committee of the American National Red Cross Advisory Board on Health Services.

Inasmuch as, on the basis of recorded scientific and medical opinion, there is no difference in the blood of humans based upon race or color, the plan does not require the segregation of blood; however, whenever necessary to insure the success of the plan, which is to make available blood and blood derivatives to all the people of the United States regardless of race or color, chapters will collect and hold blood in such a manner as to give the physician and the patient the right of selection at the time of administration.

Operating centers of the National Blood Program will be selected and established only after full consultation between the national organization and the chapters concerned. Such chapters will be furnished with complete and detailed information covering the method of organization of the chapter blood donor service, ground work for community support, public relations and promotion, the use of publicity, suggested publicity aids, the operation of the blood donor center, clinic instructions, and the relationships between chapters, area, and national headquarters.

The program will be financed through contributions made by the American people. Each year the Red Cross fund campaign will take into consideration the amount necessary to carry on this important new service.

The cost for the first year may be between three million and five million dollars. The costs of operation of the centers will be shared on an equitable basis between the national organization and the chapters.

The value received from the cost of the program cannot be estimated, for there is no way to determine the value of lives saved by having blood and blood products available when needed. One can rely, however, on the testimony of the medical profession as to what has already been accomplished and on the statement of the most eminent scientists in the blood field that we are on the brink of even greater discoveries in the uses of blood for the benefit of mankind.

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PAWTUCKET MEDICAL ASSOCIATION

A regular monthly meeting of the Pawtucket Medical Association was held at 7 p.m. Wednesday, June 4, 1947, at the Pawtucket Golf Club. This was the annual Sports Day and the golf tournament was held during the afternoon.

The meeting was called to order by the President, Dr. Earl J. Mara. As there was no new business or unfinished business a motion was made by Dr. William Kalcounos that the business meeting be adjourned until September. This motion was seconded by Dr. Albert Gaudet and passed.

Dr. Mara turned the meeting over to Dr. Earl Kelly, who presided as Master of Ceremonies. The following golf prizes were awarded.

First prize, Dr. Albert Gaudet; Second prize, Dr. Henry Turner; Winner of Putting Contest, Dr. Harry Hecker.

Door prizes were awarded to the following: Doctors Earl Mara, Orland Smith, J. Lincoln Turner, Alfred Boucher, Albert Gaudet, William Kalcounos, Charles Farrell.

Following these awards, Dr. Kelly introduced "Professor" Arthur Dooley whose anecdotes drew the usual hilarious response from all present.

The meeting adjourned at 9 p.m.

Twenty members attended.

Respectfully submitted,

KIERAN W. HENNESSEY, M.D.
Secretary

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Each PARASMA tablet contains ephedrine hydrochloride 1/8 gr., aminophylline 1 gr. and sodium bromide 3 gr. It is *indicated* in bronchial asthma to prevent or abort paroxysmal attacks and as a sustaining therapy.

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DOSAGE: *3 tablets with water. Not to exceed 5 tablets in 3 hours or 10 tablets per day. Intermittent courses of 5 days per week recommended. Caution – too frequent or protracted use may lead to bromism or anxiety symptoms. Contraindicated in cardiac or renal disease, hyperthyroidism, hypertension or diabetes.*

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THROUGH . . .  *the Microscope*

The Mayo Memorial As a tribute to Doctors William J. and Charles H. Mayo the Minnesota legislature in 1945 approved a grant of $750,000 on the condition that an equal amount be given privately for the construction of a Mayo Memorial building. This structure is to be planned as the nucleus of a medical center at the University of Minnesota devoted to the search for medical knowledge, the training of physicians, and the care of the sick. So far some three thousand corporations and individuals have contributed $1,160,000.

However, the rising cost of labor and materials halted the plans, and an additional $750,000 grant had to be forthcoming from the legislature this year, given with the same condition as the previous one. With but a quarter of a million in public subscription needed to match the State grants, the memorial fund should soon reach the three million mark to permit the construction to get under way.

Funds for Hospitals A citizens' conference on hospital capital needs of Philadelphia and vicinity met last month to make a new approach to the problem of raising funds. As a board of directors 57 Philadelphians—physicians, hospital administrators and laymen—were elected to explore and to determine whether the needs can best be met by a unified money-raising drive or by independent campaigns. Remarks from the floor during the conference indicated that there was strong support for the joint fund campaign.

Money raising at any time is not an easy task, whatever the cause for which the funds are to be used. Hospitals may be community enterprises, but each tends over a period of years to develop an individuality that affects the community population in various ways. Hence a united appeal for financial aid for all hospitals, on the surface an apparently simple way in which to create one sizable fund, is fraught with the difficulties that stem from the allocation to the individual institutions.

We have been fortunate in Rhode Island that the public has responded willing to the many appeals for help. In the Providence metropolitan area the campaigns for Rhode Island and Miriam hospitals have been well supported, while elsewhere in the state the communities of Pawtucket and Woonsocket have generously responded to the appeal for aid for the local hospitals. But for a long term plan to guarantee assistance for all the hospitals to meet necessary expansions or operating deficits the suggestion of a United Hospital Campaign may well warrant study.

Cancer Control Program With Congress more than tripling appropriations for research and control of cancer, bringing next year's budget for the National Cancer Institute to the all-time high of $14 million, the United States Public Health Service has announced plans for an expanded attack on the cancer problem that will place the disease in the forefront of the Government's medical research and control programs.

Under the broad authority provided in the Public Health Service Law and the Appropriations Act, support may now be extended to universities to assist them in developing greatly expanded cancer research and training programs. Already a total of forty-six project grants have been made to widely scattered groups.

Four million dollars of the budget has been allocated to cancer control with the program to be administered through the States to increase the effective use of present methods of diagnosing and treating cancer. This program will place emphasis on the improvement of cancer detection, diagnostic and treatment facilities; the development of refresher courses for doctors; the establishment of adequate statistical services on cancer; and the setting up of cancer control units in State Health Departments.

continued on page 624



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FORMULAC Infant Food provides a balanced and flexible formula basis for general infant feeding — both in normal and difficult diet cases.

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The only carbohydrate in FORMULAC is the natural lactose found in cow's milk—no other carbohydrate has been added. This permits you to prescribe both the amount and the type of carbohydrate supplementation required.

FORMULAC is promoted ethically, to the medical profession only. Clinical testing has proved it satisfactory in promoting normal infant growth and development. On sale in grocery and drug stores throughout the country, FORMULAC is priced within range of even modest incomes.

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THROUGH THE MICROSCOPE

continued from page 622

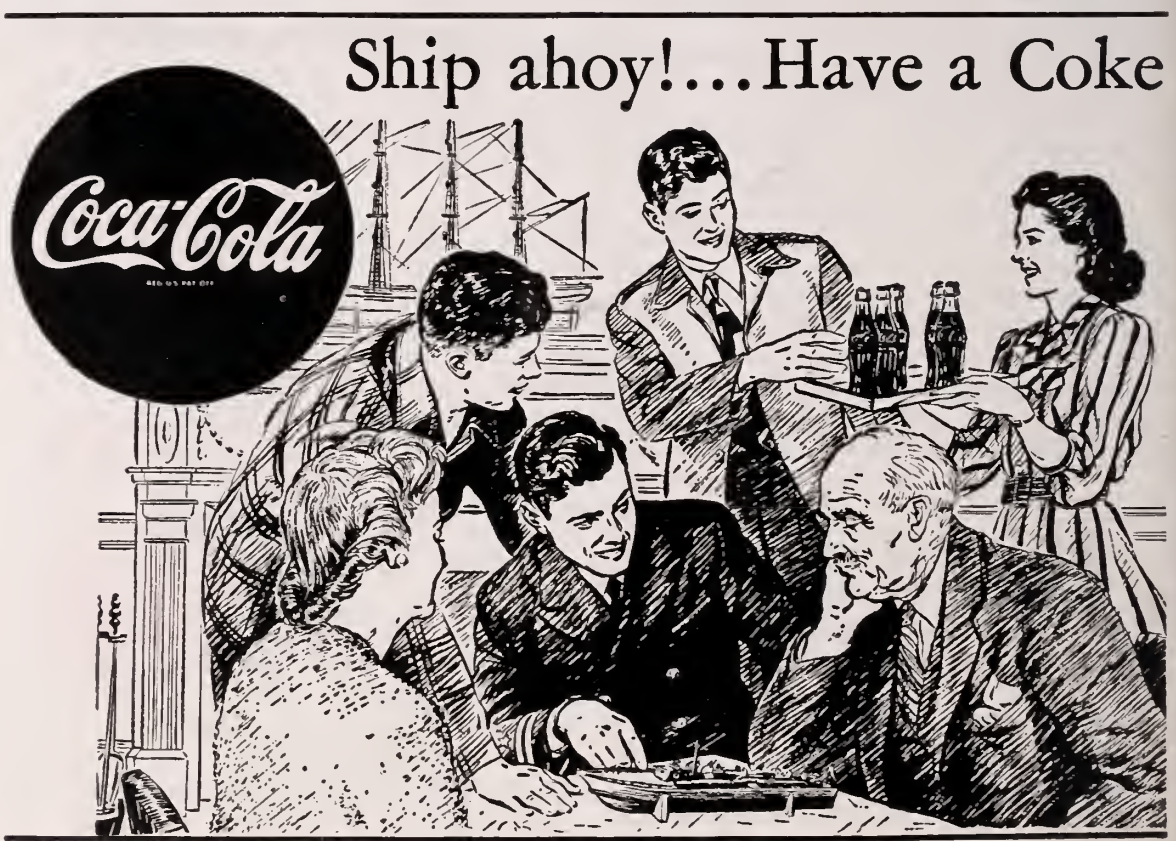
Physical Medicine The recent annual report of the Baruch Committee on Physical Medicine — a committee organized in 1944 with a grant of one and one quarter million dollars — forecast increased opportunities in rehabilitation for the 23 million Americans disabled by accident, disease, maladjustment and war. The advancements in physical medicine and rehabilitation in the period covered by the report were termed of real significance in medical history by the leading physicians and medical educators who compose the Committee. Particular emphasis was laid on research in the science of hydrology, the therapeutic use of water, a field in which Mr. Baruch's father, Dr. Simon Baruch, as the first professor of hydrology at Columbia University, was one of the original pioneers.

The Cost of Medical Education The Bulletin of the Columbus (Ohio) *Academy of Medicine* editorialized last month on the scant publicity given to the ever increasing cost of education for the physician who is to administer medical care in this country. Citing a recent survey of 50 approved medical schools, the editorial pointed out the average medical student pays out more than $7,000 for four years of medical education. This sum does not include four years of pre-medical training and the so-called fifth year of internship. Then, too, the modern trend of having all interns qualify before a specialty board for certification adds three more non-profitable years to the total school years.

Thus, cites the editorial, before the present day physician sees his first private patient he has expended $7,500 for pre-medical education, $7,500 for medical training, one year as an intern with no salary ,and three years residency at a minimum salary in order to be certified by a board. A conservative estimate, the editorial writer concludes, of the cost of education and the earning loss while in school would be $30,000.

Greatest Medical Center Underway What is planned to be the greatest medical research center in the world will be built at Forest Glen, Maryland, by the Corps of Engineers for the Office of the Surgeon General, according to a recent announcement. In keeping with technological advances in all fields, based on experiences in the late war, the center will be equipped to anticipate and meet the medical problems of the future as well as to cope with those of the present. With the initial cost set at $40 million the project will consist of a 1,000 bed general hospital, the Army Institute of Pathology building, the Army Medical Museum and center administration building, the central laboratory group buildings, and the Army Institute of Medicine and Surgery.

continued on page 626



The subject is: Allergy

The advice, as usual, is: "SEE YOUR DOCTOR"

In LIFE and other national magazines, Parke-Davis presents a timely message about allergy (shown below). It appears in full color . . . reaches an audience of nearly 23 million people. It is No. 206 in the "See Your Doctor" series published in behalf of the medical profession.

Some things you should know about allergy

No. 206 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.



MEDICAL science has discovered many interesting things about allergy.

If today you tell your doctor that you suffer from asthma, sneezing attacks, or itching eyes, one thing he considers is the possibility that you may be *allergic*—which means that you may be sensitive to some substance which causes no trouble for most people.

In discovering this offending substance (known as an allergen), your doctor acts as a detective. He may ask detailed questions about the time of your attacks, where they occur, the furnishings of your home, the food you eat.

Such questions may give him clues to the nature of your trouble. If your attacks come, for instance, in the late spring or summer months and last till the first frosts, he will suspect that your trouble is due to some pollen, that you may have some form of "hay fever."

In other forms of allergy, it is not so easy to track down the offending substance. If your case is not clear-cut, your doctor must consider hundreds of possibilities.

A few grains of mustard can make some people violently ill. A man can be sensitive to his wife's face powder, or to dog hair, or grass pollen, or to the cattle hair in the mat under a rug.

Simple skin tests are often used to reveal the offending substance. Drops of various extracts—of pollen, foods, and other substances—are injected into the skin or put on skin scratches. If you are sensitive to the substance being tested, a swelling will usually develop within a few minutes.

Once a doctor has found what causes the allergic reaction—by means of the history of the case supplemented by skin tests—he will prescribe treatment according to the nature of the patient's sensitivities.

If the patient is allergic to a particular food, the easiest solution is to avoid the food. If his sensitivity is to feathers, the substitution of a fibre pillow for a feather one may bring surprisingly effective relief.

If the allergen is house dust or pollen, or something else that cannot be easily avoided, a series of inoculations may be suggested.

Some people, however, do not respond to this type of treatment, or are sensitive to too many different things to make inoculations a practical procedure. New chemical drugs—developed to control allergic reactions in certain types of allergy—are showing promise. They are to be used, of course, only under the direction of a physician.

SEE YOUR DOCTOR. If you suffer from recurring and unexplained attacks of sneezing, skin rashes, or asthma, see your doctor. In allergy, as in other medical problems, your physician can give you more help today than ever before.

Makers of medicines prescribed by physicians

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THROUGH THE MICROSCOPE

continued from page 624

The Birth Rate Although the birth rate of 26.4 per 1,000 population including the armed forces overseas for the five month period, January to May, 1947, was nearly 40% higher than the provisional rate of 19.1 for the corresponding period of 1946, the birth rate has been lower this year than it was in the last four months of 1946 when it reached record breaking heights. The decrease has taken place in spite of the fact that marriages in 1946 increased about 680,000, or 42%, over the 1945 total of nearly 1,620,000. The estimated marriage rate per 1,000 of the population (excluding armed forces overseas) stood at 16.4 in 1946 compared with 12.3 in 1945.

Frequency Bands for Medical Diathermy Equipment The Secretary of the American Medical Association reported recently that Medical diathermy equipment may be operated on the 13.66 megacycle, 27.32 megacycle and 40.98 megacycle bands without license, according to Public Notice No. 7722 of May 9, 1947, released by the Federal Communications Commission. No limit is given to the power output that may be radiated. Diathermy apparatus operated outside the assigned frequency bands above shall be completely shielded and filters placed in the power line. The Commission will determine if the diathermy equipment is not operating in compliance with the rules and in such cases will notify the owner, who is responsible for making the changes to prevent interference.

All equipment manufactured before July 1, 1947, will *not* be subject to the new regulation for a period of 5 years (June 15, 1952).

A special band at 2450 megacycles has been made available for industrial, scientific and medical purposes. This is to allow the production of experimental machines of extremely short wave length —approximately 12 centimeters long. Such machines have not been used by the medical profession up to the present time. However, this channel may be subject to development in later years as the medical profession either accepts it or not.

Your Doctors—1947 The headquarters staff of A.M.A. recently reviewed the latest March of Time Film "Your Doctors—1947." With the possible exception of overemphasis on psychosomatic medicine and specialization, the film is good. Principle locale is New York (New York Academy of Medicine and Mt. Sinai Hospital) with a few shots of the Lahey Clinic in Boston. The film shows a brain operation; the use of the artificial kidney; an RH transfusion performed on a new baby, and the use

continued on page 628



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Some Demerol* Advantages——
Danger of respiratory depression greatly relieved.
Does not interfere with cough reflex or cause constipation.

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In manifest vitamin deficiencies it is inadvisable and impractical to rely primarily on dietary correction. The deprivation of essential nutrient factors usually has existed for many years, and it is important to give adequate treatment in order to restore health promptly. Pluraxin is especially designed for intensive vitamin therapy.

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Vitamin A (from fish liver oil)	25,000 U.S.P. Units
Vitamin B_1 (thiamine)	15 mg.
Vitamin B_2 (riboflavin)	10 mg.
Vitamin B_6 (pyridoxine)	2 mg.
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Calcium pantothenate	10 mg.
Vitamin C (ascorbic acid)	150 mg.
Vitamin D_2 (calciferol)	1,000 U.S.P. Units



One capsule of Pluraxin daily is usually sufficient. Some patients may require larger doses during the early stages of treatment. In vitamin therapy, "it is far better to prescribe too much than too little, too soon rather than too late" (Spies). Available in bottles of 30 and 100 capsules.

PLURAXIN

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THROUGH THE MICROSCOPE

concluded from page 626

of atomic isotopes in treating cancer of the thyroid. On the psychiatric side, the shots of the young child deprived of its mother were particularly effective. The film will be shown in your neighborhood theatres shortly.

Obstetrics and Gynecology Our last report indicated that at least twenty physicians from Rhode Island will be among those in attendance at the third American Congress on Obstetrics and Gynecology when the session starts on September 8 at St. Louis. Aiming to hold a meeting that will be of value not only to the obstetric-gynecologic specialists but to those who come in contact with the greatest possible number of maternity cases—the general practitioners—the Congress promises to attract a sizable nationwide audience of physicians. Further information on the meeting may be secured by writing the Congress office at 24 West Ohio street, Chicago 10.

Public Relations The recent announcement by Boston University that it will inaugurate a course in public relations is the first attempt with which we are familiar to solve the riddle of what constitutes a public relations expert. The resignation in June of the Raymond T. Rich Associates (Rich is a Brown '22 alumnus) as public relations consultants to the American Medical Association has provoked much discussion of the whole field of medical public relations. Even our junior Senator has made quite an issue of the Rich incident in his statements to the Congressional committee studying the national compulsory health tax plan. But if Mr. McGrath thought the Rich report something to quote he should take time to evaluate the "profound research" (four days by one expert, and five by another) that resulted in feature sections on the state health department, and the state institutions, in the voluminous tax commission study in Rhode Island this past Spring. Our locally appointed voluntary commissions reported clearly and convincingly for years to Mr. McGrath and his predecessors in public office about needed improvements in welfare and health, but their recommendations have been filed away without action being taken.

Research Fellowships The American College of Physicians announces that a limited number of Fellowships in Medicine will be available from July 1, 1948-June 30, 1949. These Fellowships are designed to provide an opportunity for research training either in the basic medical sciences or in the application of these sciences to clinical investigation. They are for the benefit of physicians who are in the early stages of their preparation for a teaching and investigative career in Internal Medicine. Assurance must be provided that the applicant will be acceptable in the laboratory or clinic of his choice and that he will be provided with the facilities necessary for the proper pursuit of his work.

The stipend will be from $2,200 to $3,000.

Application forms will be supplied on request to The American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa., and must be submitted in duplicate not later than November 1, 1947. Announcement of the awards will be made as promptly as is possible.

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Pyridoxine (B_6)	2.0 mg.
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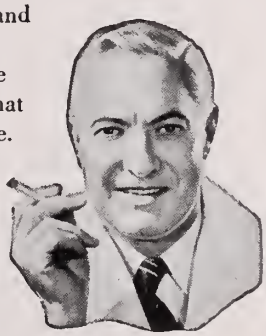




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★ ★

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They are the safest investment in the world. Buy them regularly through the Payroll Plan, or ask your banker about the Bond-a-Month Plan.

Save the easy, automatic way—with U.S. Savings Bonds

Contributed by this magazine in co-operation with the Magazine Publishers of America as a public service.

1848...

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JANUARY, 1948,

the Rhode Island Medical Journal desires to secure the loan of any old Photographs of early scenes of Providence, and of physicians prominent in the city in the years past. All photos should be forwarded to the Executive Office of the Association.

...1948

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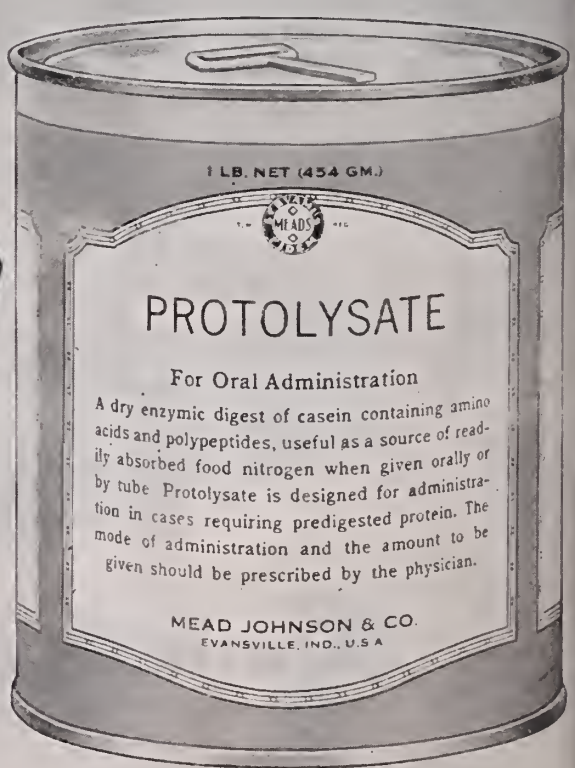
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Monday, October 6, 1947 at 8:30 P.M.

THE RHODE ISLAND MEDICAL SOCIETY • HOSPITAL ASSOCIATION OF RHODE ISLAND

Volume XXX, No. 9

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CARTOSE supplies carefully balanced amounts of non-fermentable dextrins, with maltose and dextrose. These offer the advantages of: spaced absorption because of the time required for hydrolysis of the higher sugars : less likelihood of distress due to the presence of excessive amounts of fermentable sugars in the intestinal tract at one time.

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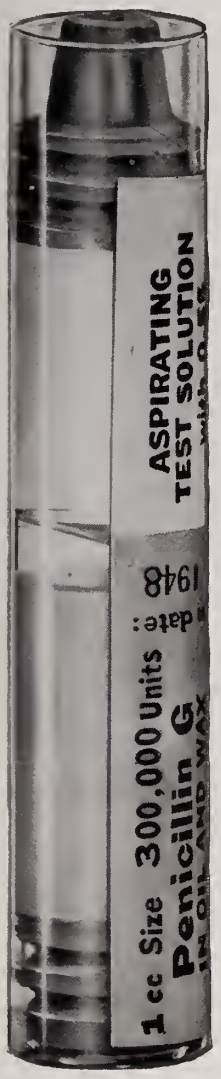
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Save the easy, automatic way—with U.S. Savings Bonds

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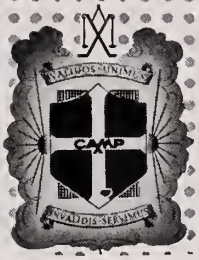
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*J. A. M. A. 129:1080. December 15, 1945.

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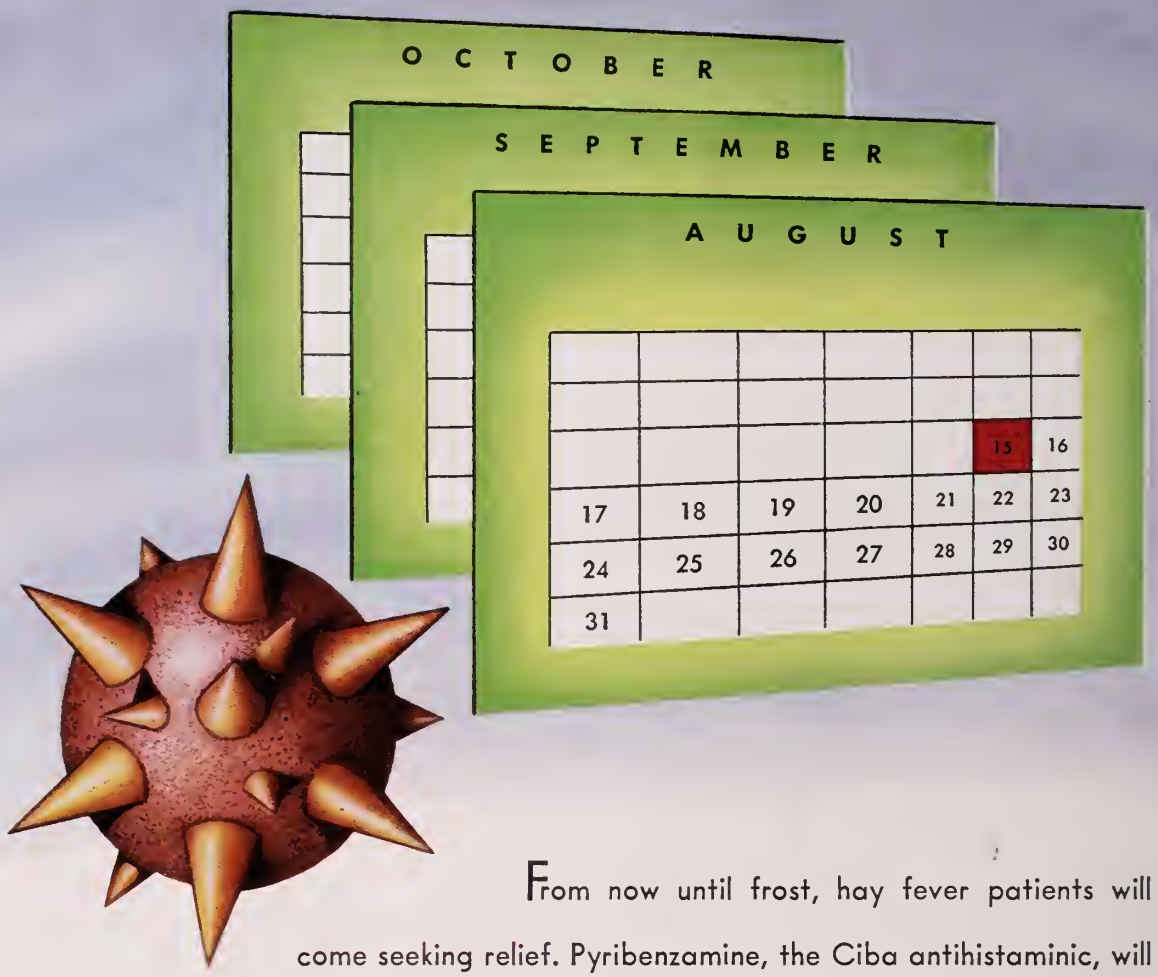
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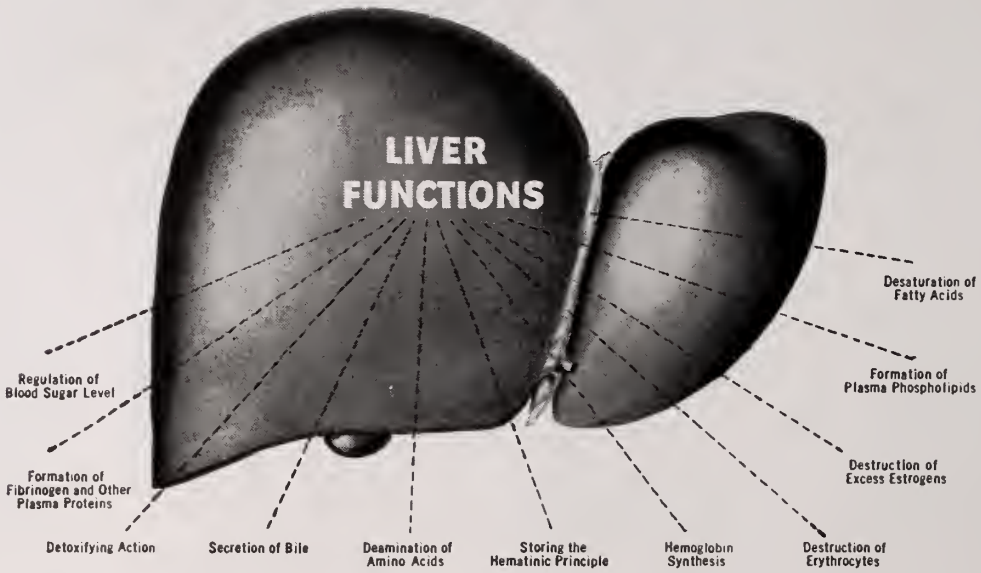
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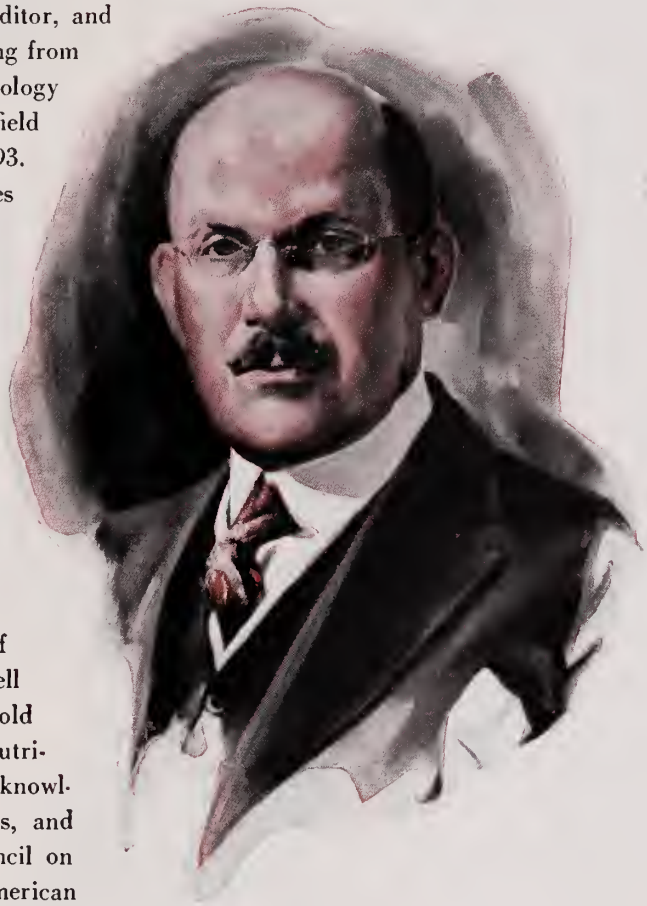
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For many years, Mendel collaborated with the distinguished investigator of vegetable proteins, Thomas B. Osborne, conducting valuable researches on the comparative biologic value of proteins of differing amino acid composition, as well as in other fields of nutrition. His manifold contributions to our understanding of nutrition in the chemistry of life were acknowledged in numerous lectureships, honors, and awards. He was a member of the Council on Pharmacy and Chemistry of the American Medical Association from 1917 until the time of his death, and of the Committee on Foods from its inception.



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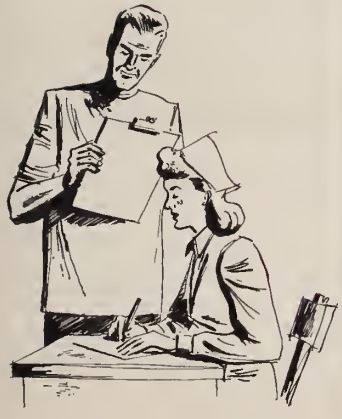
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXX SEPTEMBER, 1947 No. 9

CERTAIN ASPECTS OF PROBLEM DRINKING

CHARLES H. DURFEE, PH.D.

The Author. *Charles H. Durfee, Ph.D., of Wakefield, R. I. Director, Rocky Meadows Farm, Wakefield; Graduate of Yale University and the University of Vienna.*

"Drink it and you will hear the voices of men and maidens singing the 'Harvest Home' mingled with the laughter of children — for many years this liquid joy has been within the happy staves of oak, longing to touch the lips of men" — ALCOHOL.

RECORDED HISTORY is replete with references to drinking, and we may reasonably assume that men and women drank before they learned to write. Anthropologists find primitive tribes using fermented beverages; archaeologists discover liquors in the tombs of ancient civilizations; scholars ponder a considerable literature devoted to all the aspects of drinking. Plutarch was revolted at the spectacle of drunken Mark Antony; Horace reposed on the Sabine Farm and sang the joys of Massic and Falernian wine. Polytheistic religions commonly had a place for a drunken god in the anthropomorphic pantheon. An international wine trade flourished in mediaeval Europe. And so on, and on; only occasionally has a social order lived completely out of touch with alcohol. The history of man's association with drink is long in time and globe-circling in space.

In this record the use of liquor seems to have had two major aspects, even as it has today. The brighter side presents drink as "the servant of man"—in religious ritual, in pleasant conviviality, in alcohol as a useful drug for the physician to prescribe. Alcohol here has been an adjunct to living. This is its major role. In contrast to this sun-warmed face of drinking is the shadowed night of liquor's tyrannical mastery over many men and women (large in number, though small in the percentage of those who drink), a mastery that has given us an increasing procession of inebriates, bearing on their backs the burdens of poverty, crime, withered hope, and lost love. With this darker phase of man and alcohol we are concerned in this paper, in the effort to understand, as fully as we can, drinking as a problem.

Certain pathological symptoms may be traced to habitual and excessive use of alcohol; these symptoms are said to be signs of chronic alcohol poisoning and personality deterioration. In medicine, the phrase, chronic alcohol poisoning, is recognizable and handy. The use of the term "chronic alcoholic" to classify a person given to abnormal dependence on alcohol is inadequate and misleading, however. The connotation of the phrase, "chronic alcoholic", in law, in criminology, and in sociology has assumed a strong suggestion of moral stigma. In the treatment for excessive drinking, this suggestion of weakness and moral unfitness may do serious psychological harm to patient and therapist alike in discussing the problems posed by alcohol. An understanding of the life patterns of drinkers will reveal that the simple phrase, "problem drinker", is a more accurate term for describing a person unable to stop drinking of his own volition.

A problem drinker is a person in whose life drink overshadows, threatens or has already destroyed what we consider normal living: his job may be in jeopardy or lost; his place in his family may be dislocated; he may shun or be thrust away from participation in group activities; and, from his point of view, a drink may be of more immediate importance than the salvage of his remain-

continued on next page

ing years. He may even realize, in sobriety or drunkenness or a half-state between the two, that drink is the central problem of his life, and that he chooses to stop drinking. He may eagerly desire to return to complete sobriety, a state which he can recognize as being infinitely preferable to his misery. But he does not know how to stop. He does know, however, that an immediate and effective temporary balm for his unhappy confusion is close at hand—another drink. This person is a problem drinker.

The symptoms of problem drinking are definite, but their significance not always recognized; they may be obvious, annoying, and often tragic to the drinker and his associates for an extended period of time, even years. An inordinately protracted drinking bout may, after many seasons of drinking, accelerate the onset of a psychosis, delirium tremens, or acute alcoholic hallucinosis. The excessive drinker is highly vulnerable to the distressing results of deranged judgment in social life, in business and monetary affairs, and in his own orientation to the heavens above, the earth beneath, and the waters under the earth. And he has few or no defenses against the onslaughts of blind but omnipotent circumstance.

There are symptoms of whose significance the incipient problem drinker should be made aware. The appearance of any one or more of these symptoms is a warning, if it could be made plain and convincing to the drinker, that alcohol is no longer his friend, that he is headed into a losing battle with liquor.

1. To black-out, or "to draw a blank." Certain drinkers, at a point in fairly rapid imbibing, lose memory for immediately subsequent events. They may walk about, patently drunk, seemingly half-conscious but still approximately upright; they have the ability to demand and take another drink. Memory for events which happen while they are in this condition is frequently not recovered. Even after the concentration of alcohol in the blood has been reduced by oxidation and the drinker has had more or less sleep, he will often know what he did only by being informed. This symptom is not at all uncommon, and it may be a first sign of an as yet undiscovered physiological change in the body owing to alcohol poisoning.

2. Extra-curricular drinks. An incipient problem drinker usually needs drinks more rapidly than do other people in a drinking group. He may feel that the pace is too slow. He may be apprehensive that the liquor will be used up before he has enough to satiate him. He may think the highballs too weak. He may ask for a martini without olive, a manhattan without cherry, an old-fashioned without fruit in the hope that the volume displaced by these encumbrances in a glass will be compensated by increased liquid measure. At a party, he may take a station near the source of the liquor supply and not move far from it. He may go to the pantry as a guest or as a host to take an extra drink. He may fortify himself before going to a cocktail party. He may slip away from work at any time of day for a quick drink or two. His intake is increasing, and he is looking for a crest of euphoria beyond the crest given by a normal quota of drinks; or he is looking for oblivion.

Pantry-drinking, quick ones, a rapid pace, and other extra-curricular drinking are sure symptoms of incipient problem drinking.

3. An unwillingness to talk about liquor as a problem in his life is an indication that a person has become a problem drinker. This reticence is largely a result of feelings of guilt, conscious or unconscious. Coupled with this is a state of irritability, a readiness to accuse friends and family of imagined slights and wrongs. Thus, a problem drinker may accuse a friend of disloyalty, a wife of unfaithfulness, a child of disregard, the world in general of lack of appreciation, for the most part because he has feelings of guilt toward all these persons, feelings of which he is unaware.

4. Rationalization. Only the utterly abandoned derelict, the feeble-minded, and the psychotic drink without trying to justify it to themselves and to others. A successful or a disappointing working day, a witty or a dull party, a charming wife or a drab at home, good luck or bad, good health or frayed nerves—the catalog of adduced reasons for drinking has probably changed little in thirty thousand years; the list is limited only by the bounds of man's inventiveness. The final word on this aspect of tippling was spoken by a seventeenth-century poet:

> If all be true that I do think
> There are five reasons men should drink:
> Good wine, a friend, or being dry,
> Or lest we should be by and by,
> Or any other reason why.

When rationalization is carried over from justifying a few drinks to justifying a succession of drinks, with no considerable period of abstinence, then the familiar mental pattern of the problem drinker has taken shape. The reasons he puts forth for his drinking will depend upon his environment and how his mind works. It is common to hear such a drinker say, "I drink no more than anyone else." "Everyone else drinks. Why shouldn't I?" "My work is nerve-wracking — or boring and dull; drink is a help to me." All such rationalizations are part of the pattern developed by man to keep from facing up to reality.

5. Unwillingness to attend meetings, dinners, and social functions where liquor is not served is an indication that alcohol has lost its true relative

value to its victim. This unwillingness carries over to refusal to sit through concerts, lectures, moving pictures, plays; to drink anything but strong liquor, preferably undiluted. The prospect of a drink is more pleasing than any other aspect of a party, a conference, a day, or an hour of relaxation.

6. Change in the character of hangovers. A novice at heavy drinking finds himself on the morning after such excesses with a headache and marked fatigue. A chronic drinker's hangovers, however, are like no other ailment known to man: He is painfully tired; his muscles ache; he usually has tremors. The tremors may become so bad that he may have to take his first morning drink sitting braced in a corner on the floor (a procedure during which he has been known to chip an upper incisor as he shakily raises cup or mug to his lips). He may suffer severe gastric distress, with vomiting, retching, and diarrhea. Psychologically he is the prey of morbid apprehension, vague but inescapable fears, feelings of guilt and shame. He is about as thoroughly miserable as a human being can be. In the misery of his hangover, the aspirin, black coffee, and fruit juices of a more resilient and youthful day are not his need. Alcohol alone will temporarily bring relief. As the day progresses, he will have to maintain a steady intake in order to feel normal. By nightfall he has a heavy concentration of alcohol in his bloodstream and is apt to end up in a rotation of maudlin, bitter, and unenjoyed drunkenness. After long years of drinking, one of his sprees may culminate in delirium tremens or acute alcoholic hallucinosis.

7. Gastro-intestinal disorders. The gastro-intestinal tract of a habitual drinker takes severe punishment. This is indicated by a failing appetite, particularly at the beginning of the day. Here again, however, the drinker has learned that one or two drinks will restore his appetite; hence he is apt to resort to alcohol to relieve this symptom. After a continuance of such drinking he will eat less and less, until alcohol becomes both food and drink to him. The result is a vitamin deficiency found in most excessive drinkers — the basis of nephritic and other conditions.

8. Insomnia and irritability. These two conditions are characteristic of the problem drinker, and may have serious consequences psychologically both for himself and for his family. Frequently the children of problem drinkers develop behavior difficulties due to their insecurity, induced by the irritability, inconsistency, and sometimes abusiveness of a parent. For insomnia, as for other results of nervous tension, the drinker has learned the efficacy of more alcohol as a temporary relief of these symptoms.

A person who finds himself with any one of these symptoms is in the gravest danger of becoming a true compulsive drinker. Could his state be made perfectly and fully clear to him at the onset of any of these results of drinking, he might be saved from the messy life that awaits him if he continues to drink.

It is true that arresting a case of problem drinking is one of the most difficult tasks for the therapist to perform. Probably a harder job, however, is to prevent, surely and completely, a person's entrance into the particular and personal hell that is the problem drinker's. For one of the curious facts about alcohol, and one of the most significant, is, as we have seen, that alcohol itself is a certain though temporary specific for the ills born of overdrinking. Physiologically, a drink will relieve alcoholic gastritis and tremors. Psychologically, a drink may overcome insomnia; dull the vague fears and apprehensions common to habitual hangovers; banish feelings of guilt which assail the mind in moments of comparative sobriety; and sometimes allay nervous irritability. In small concentrations it engenders a feeling of ease and relaxation; it gives some courage, though not skill in facing the consequences of irresponsible action.

The problem drinker knows by experience all these attractive aspects of a drink or two. When, therefore, with his psychological and physiological brakes irreparably damaged, he finds himself resorting to liquor to assuage the difficulties resulting from liquor, he has set in motion the swing of compulsive drinking—from drink to trouble, to drink again—the classic pattern. And the laws of inertia are valid here as elsewhere: a body in motion tends to remain in motion.

The especially vicious phase of this swing is that the victim knows of no aid for his condition except the treacherous palliative of more alcohol. Hence he is usually actually afraid to stop drinking. He does not want to be left out on a limb. No matter how many times drink may have robbed him of his dignity or his honor, he treasures naively the hope that it will not do so again.

Susceptibility to becoming a victim of alcohol varies among men and women. Great interest is frequently expressed in the question of who is likely to develop into a problem drinker, and much has been written about the many factors—sociological, physiological, and psychological—which from time to time seem to play incisive roles in producing the swing of the problem drinker's compulsion. Without question, problem drinking often is one manifestation of a poorly adjusted, immature personality; it may be caused by frustration, or it may be a means of escape from difficulties common to the struggle of life. Some students of alcohol addiction maintain that the problem drinker is first a neurotic, and later, as a result of the neurosis, a drunkard. On the basis of my own observation,

continued on next page

this is by no means universally true. One need not be a neurotic to get into trouble with drinking. Many men can drink with impunity for years, with no disruption of the normal reactions of life. Sooner or later, however, by means of long and frequent exposure, and by psychological habituation, even the individual with a so-called integrated personality can develop sufficient dependence on alcohol to become a problem drinker.

Psychological habituation is a significant factor in the drinking history of both the maladjusted personality and the normal person. More than any other causative element, routine drinking can make alcohol, a drug not physiologically addictive, the object of irresistible craving. We all know how disturbing even minor dislocations of routine can be—failing to get one's coffee or morning paper at breakfast, or missing a train. Alcohol, more intimately related to subjective and physical states such as worry, depression, and fatigue, is particularly suited to become a habit, especially if indulged in as a regular practice over a period of years. To psychological habituation must be added an acquired tolerance, so that increased quantities are necessary to produce the desired effect.

Thus the so-called integrated personality can, by prolonged practice, develop a drinking problem too great for him to handle by himself. Even as the neurotic drinker, although probably not as soon, he may come to need assistance in resolving his problem.

The picture here presented of the problem drinker is one of an ailing man, and a man very likely confused about the real nature of his illness. To some problem drinkers there remains a measure of insight and objectivity—buried, usually, under the alluvial deposits of years of stultified intellect, and atrophied decision. This objectivity and insight may become apparent in a drinker's ability to see himself as others see him, in a realization that somehow he must return to the main highroad of life, in the sure knowledge that he did not choose and would not choose the quicksand to which his path has led him. His awareness at this point will count heavily in his return to sobriety. Or, he may be shocked into the desire to stop drinking. He may have lost his wife or his job; he may have dissipated his fortune, small or large; he may be appalled at the ghost of a man he has become in his own eyes. However he may dredge up into full consciousness this insight, it is the basic factor in successful rehabilitation therapy. In my experience an individual usually must hit rock bottom before he is ready for re-education.

Such insight might appear to be inevitable after a person has taken repeated beatings from alcohol. Unfortunately, this is not true. A man may have had proved to him many times that he cannot handle liquor, yet doggedly assert that his next experience will close happily. Or, in spite of overwhelming evidence to the contrary, he may persist in the attitude that he has no problem at all. Many men build compartments in the mind which are impervious to logic and to empirical knowledge. Again, many patients display what may be called pseudo-insight, a misleading willingness to discuss their problems fully, even with embellishments, and a show of contrition and eagerness to co-operate that is only a surface manifestation; these patients lack real conviction about the profundity and complexity of their troubles. The true attitude of a patient will become apparent in the course of therapy.

Objectivity and insight, then, are essential to the patient who enters a course of treatment. In addition, he must have a positive desire for help. This desire for help is a sign of an instinct for living, a will to survive. In this connection, a rather common misconception about "will power" and its application by the problem drinker may be observed. Perhaps many times a problem case has been told, "Be a man! Use your will power! Stop drinking!" With the very best of intentions, with hope and good will, friends, employers, members of the family, clergymen, and personal physicians will talk to a drinker in these terms. In the majority of cases, the results of these adjurations are more harmful than salutary. Self-reproach is characteristic of the problem drinker, and such categorical imperatives often do no more than emphasize and concentrate feelings of inferiority and shame, so that the purpose of the advice is defeated: the recipient of the lecture may very well seek a drink to relieve these sharply etched feelings. This is not meant to belittle the achievement of those men who do stop drinking by sheer resolution and determination. But their numbers are few in contrast to the many who were unable to rule drinking out of their lives by fiat. Furthermore, the person who becomes and remains for some time an abstainer by dogged persistence alone is apt to live with a drink problem throughout his period of abstinence, no matter how long or short this period is. The place of the will in unlearning to drink is fundamentally in the instinct for preservation of the individual, in the desire and expectation of survival, and in the readiness to meet life on its own terms. Some patients may have insight, oddly enough, but lack this foundation of serious intent; perhaps unconscious suicidal motivations are present.

Another important prognostic index is the patient's occupational history. In comparison with his drinking history, his record of work and accomplishment is more significant. In our own experience neither the quantity nor the duration of

a person's drinking determines the prognosis in any given case, provided, of course, there has been no serious deterioration, psychologically or physiologically. A person who has worked with regularity for a considerable period of time, who has been constructively occupied in a job, a business, or a profession with some degree of success, who can point, in short, to a record of continuity in his work history is probably a basically well organized personality. He has relative stability. Consequently, an individual in middle age may be a more encouraging prospect for rehabilitation than a youngster. The younger man, with no special training, no developed aptitudes, and only a sporadic occupational history, may be youthfully unaware of his responsibilities. He is faced with the competition of life, which for the older man has somewhat abated. He must make rapid psychological adjustments no longer demanded of his senior. Although the younger man's drinking history may be shorter, the burdens, the conflicts, the disappointments, and, as well, the successes that life holds in store for him make emotional demands he may not meet soberly. When a drinking problem develops early in life—unless it is the result of adolescent revolt—it may indicate the presence of a deeply rooted psychological deviation. The older man, on the other hand, with a continuity of work, a record of some stability, the possession of insight, and the positive desire for help, offers the therapist greater promise of a hopeful prognosis.

Insight, desire for help, and occupational history give the therapist the cornerstones of his carefully planned treatment. Complicating factors in the mind of a problem drinker, however, may prolong or even defeat the successful conclusion of therapy. The problem drinker is often in a foggy state of mind, removed from the world of objective living. Pathological feelings such as fear, inadequacy, jealousy, envy, hatred, and worry often have been magnified and compartmentalized by alcoholic excess. Bitter resentments, by habitual pondering in habitual inebriety, have taken possession of the drinker's mind with a strength out of all proportion to any habit of objective living. To lead the problem drinker from this vast, resounding hall of abnormality, the therapist must open the door to real life.

The door to reality can best be opened by means of a real-life situation, in an environment of understanding and freedom from tension. For the voluntary patient, confinement within institutional walls is usually not necessary. The patient with insight and the instinct for living needs sympathetic supervision and understanding rather than restraint. Freedom from tension under confinement, too, is sometimes difficult to give a person who may associate restraint with punishment, and who is in a panic state as he faces the prospect of alcohol withdrawal.

The demonstration that confinement is usually not required can be found in the measurable success of several agencies. Consultation work by able therapists has many times been of notable aid to certain patients. An occasional man will learn enough in one hour with a consultant to be able to say, and to mean it: "Finished." Others are helped by a series of consultations, extending over weeks or months, even over a year. Some problem drinkers respond favorably to the example and precept of others who have given up drinking. Out-patient attention by members of the staffs of some hospitals has been effective in many cases; attendance at clinical lectures and guided reading have been of value to some problem drinkers. Groups like Alcoholics Anonymous have given many men and women the support and sympathy and the knowledge to enable them to rebuild their lives. Voluntary patients fortunate enough to find these skilled services proximate and available have often derived great benefit from them. It is significant that confinement is usually not recommended by these therapeutic agencies. If a man has a job, he need not leave it when he seeks help in these quarters. The real-life situation is of inestimable value as the *mise-en-scène* for the re-educational process.

Sometimes a person may be so perturbed by situational factors, however, that it is wiser to recommend his removal from his particular environment until he is able to meet its difficulties without recourse to alcohol. For example, a set of rationalizations, confirmed and exaggerated by drinking, has often a basis in fact. A patient who may seem to rationalize his drinking by speaking of an unhappy marriage may have foundation for his conviction: incompatibility is found in marriages between temperate men and women. The bitter resentments characteristic of the problem drinker, magnified by inebriety, may have arisen from a real hurt or disappointment: seeming friends are sometimes disloyal; unselfish, idealistic men are sometimes crucified; the sensitive man has known "the oppressor's wrong, the proud man's contumely"; the egocentric can hardly call this the best of all possible worlds. There may be economic involvements too complex for an ailing man to solve as he also tries to regain sobriety; legal tangles may burden him with worry; he may be working at a job wholly unsuited to his temperament—many situational factors in his life may so occupy his mind that consultation, clinical advice, or Alcoholics Anonymous cannot show him a positive way to solve his problems and at the same

continued on next page

time free himself from the swing of compulsive drinking. This patient comes most often from urban centers. A drink problem and the complication of distressing situational factors can be too much for a person to handle simultaneously. Certainly the first step to take is to stop the momentum of compulsive drinking, and this step is best taken in a place removed from the habitual milieu of the patient's life. This man needs to go, with King Arthur, after the turmoil of climactic and tragic battle,

'To the island-valley of Avilion;
Where falls not hail, or rain, or any snow,
Nor ever wind blows loudy; but it lies
Deep-meadow'd, happy, fair with orchard lawns
And bowery hollows crown'd with summer sea,
Where I will heal me of my grievous wound.'

A small farm may offer an altogether salubrious setting for the re-education of such a patient. Here he can have rest, moderate exercise, fresh air, sunshine, proper nutrition, and motivated occupational therapy. Here, also, the therapist can take full advantage of the patient's objectivity and insight, and give him the means and the opportunity of seeing alcohol and his life in reasonable perspective.

The approach to therapy during the first few hours and days in such a setting is a most important period in treatment, for at this time the therapist must establish in the patient confidence and trust upon which future suggestions for his help can be based. The new arrival probably is in a panic state: he may be intoxicated to some degree. At best he is unsure of himself and in fear of the worst that may happen to him in the way of drastic and bizarre methods of treatment. He is uneasy at the prospect of being at once deprived of alcohol, and envisions strict and constant supervision to prevent his sneaking drinks. The vague but very real apprehensions to which drinking has made him subject have at this time a new field for his imaginative powers. Fears on this score can be quite distressing; many individuals come burdened with misconceptions based on the folklore connected with the treatment of compulsive drinking, folklore in part associated with melodrama little short of black magic. These illusions contribute to the panic state of the new arrival. Incidentally, the notions reveal something of the inadequate knowledge of the problems of alcohol, especially in regard to enlightened therapy.

Instead of finding his conjectures confirmed, the new man should find understanding and assurance; he is not told that he has been a cause of heartbreak or tragedy; he knows very well all the counts on which he can be charged, and has remorsefully charged his own conscience with them many times. Inconsequential questions and friendly small talk suffice at the start. As soon as possible, he should be given a complete examination by a physician, who prescribes a regimen which may include diet, supplementary vitamin injections, sedation, exercise, and so on, suitable to his individual needs.

In mentioning sedation, we may well pause to consider the sedative effect of alcohol, and its usefulness in the withdrawal stage for problem drinkers. The abrupt discontinuance of alcohol is recommended by many therapists who find psychological value in demonstrating promptly that alcohol is not essential and that there is no true, physiological addiction. But as a sedative, alcohol, judiciously apportioned by a physician, is an effective and not at all harmful means of carrying a patient through the stage of withdrawal. Often patients have a fear of sedatives. Others have combined drinking with various forms of sedation, from the more common hypnotics to the opiates. From time to time problem drinkers have become addicted to opiates because, during some phase of their drinking history, a physician has prescribed these drugs to aid them over an acute episode. Repetition of this treatment in subsequent drinking bouts may complicate a drinking problem with that of drug addiction. Alcohol, on the other hand, provides effective sedation and may be withdrawn without complicating after effects when it has been given in a supportive environment without threat or tension. The patient is thoroughly familiar with the sedative effect of alcohol; furthermore, he is apt to be more co-operative and freer of resentment when alcohol is not sharply taken from him. His independence of alcohol can be demonstrated to him convincingly by less drastic and seemingly punitive methods than its immediate and forcible removal. In the tapering-off process, a patient with hopeful prognosis will invariably refuse a drink of his own accord at the end of seventy-two hours or earlier.

Only when a patient has relaxed and is at ease can the re-educational process properly begin. Serious therapeutic interviews are profitless until a man has at least started to regain his health. These interviews, which may be informal and at no appointed hour, offer the patient the opportunity of understanding in detachment and objectivity the nature of alcohol in relation to his life. The re-educational process can have no set formula, for individual histories, situations, and responses vary widely. What may be effective in one man's case may be ruinous in another's. The goal of the re-educational process is, without compromise, total abstinence.

The ideal progress of a patient is recorded in the gradual, almost imperceptible growth of personality under the influence of positive precepts

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IS ASTHMA A SYMPTOM OR A DISEASE?*

FRANCIS M. RACKEMANN, M.D.

The Author. *Francis M. Rackemann, M.D., of Boston, Massachusetts. Physician, and Chief of Allergy Clinic, Massachusetts General Hospital; Lecturer in Medicine, Harvard Medical School.*

DR. RUGGLES, members of the Rhode Island Medical Society, and Ladies and Gentlemen: I recall with pleasure a meeting of several years ago in which the personnel of the allergy clinic of the Massachusetts General Hospital staged a sort of vaudeville show in this room! At that time, we discussed the details of history-taking; diagnosis and treatment of asthma.

Since then we have arranged our thoughts in a reasonably logical manner and the result is this classification.

A WORKING CLASSIFICATION OF ASTHMA

ASTHMA BEGINS BEFORE AGE 30

"Extrinsic" (Allergy)

Simple

Diagnosis easy by History

Complicated

By infections
By "Depletion"

"Asthmatic Bronchitis"

V.M.R. leads to Asthma

(often severe.)

ASTHMA BEGINS AFTER AGE 40

"Intrinsic"

Bacterial Allergy—(hard to prove)

"Depletion" Psycho—Fatigue

Somatic

Infection / Malnutrition — Sinuses, Bronchi, Teeth, Other

(Note Selye's "Alarm Reaction")

"Polypoid Sinusitis"

Emphysema — Functional / Structural

Tumors and *Foreign Bodies*

The title of my paper is the question: "Is Asthma a Symptom or a Disease?" It sounds somewhat academic, but nevertheless it is a practical question, because if, on the one hand, asthma is merely a symptom, it is perfectly proper to go on as we have been doing and try to find the various reasons why it is that people wheeze. If, on the other hand, asthma is a disease, then we must look beyond the wheeze itself and see if there isn't some basic principle which applies to all the cases at the same time. I would like to trace our thoughts in these directions.

This classification brings out the difference between the "young lady" on the left and the "old gentleman" on the right of the mid line. The young lady is allergic: She is sensitive to ragweed, or perhaps to feathers; she presents a classical picture; her troubles occur only on certain definite occasions — they depend upon her environment.

In such a case the diagnosis should be easy. It is the clinical history with its dates and with the symptoms correlated with changes in residence or occupation which will show that the asthma occurs when she goes to see "Aunt Mabel" and at no other time. Skin tests are useful to confirm the history. In this case they may show a reaction to cat hair!

Simple asthma is sometimes complicated by other factors. The attacks last longer than they used to, perhaps because a pharyngitis or sinusitis keeps it going. I am delighted that I could be here today to hear Dr. Pitts discuss the importance of

continued on next page

*Presented at the 136th Annual Meeting of the Rhode Island Medical Society, at Providence, May 15, 1947.

psychic factors. I believe he had in mind much the same thing that I call "Depletion." There is little doubt but what fatigue of body and soul or both can make a simple asthma worse.

On the right-hand side of the table, asthma begins after age forty. The "old gentleman," the tired business man, or the harassed housewife, come into the hospital, and instead of clearing up in two or three days as does the "young lady" their asthma persists in the hospital. Environment plays no great part.

In this group the cause of trouble is "intrinsic"— it is something which the patient carries with him. There are various sub-groups: *"Bacterial allergy"* is described but the mechanism of it is hard to prove. Skin tests for ragweed or egg-white, or feathers are perfectly definite, and the reactions appear in fifteen or twenty minutes.

With bacteria, however, with toxins or vaccines, skin tests appear late — in twenty-four hours — as an inflamatory area entirely comparable to the tuberculin reaction and I ask you, what significance would you put on the finding of a positive tuberculin test, in the skin of the tired business man, or of the harassed housewife, who felt perfectly well all of his or her life until the age of forty-five?

It is possible that tuberculosis might be the cause of the asthma. But, the fact is that the patient has not got tuberculosis; x-ray does not show it, and patient does not do the things that he should do if he had tuberculosis.

Meantime, however, you will recall that in pneumonia at the time after recovery when antibodies are numerous in the serum, that a skin test with the specific carbohydrate substance will bring out, as Francis demonstrated, an immediate urticarial reaction. Such a test demonstrates antibodies attached to skin cells, and it may be that further study will find the method useful in asthma — as a proof of "bacterial allergy."

The next item interests me more. *What is "depletion"?* Sometimes depletion is psychic, and I think again of the sound advice which Dr. Pitts has just given. Other times, however, depletion is somatic. Physical examination is always important, and the more complete it is, the better. There are people whose asthma has been relieved entirely by pulling a bad tooth or draining an infected sinus, or removing gallstones, or taking out a fibroid uterus, or giving a little iron and raising the hemoglobin from, say 12 grams back up to 14 grams. Physical examination, the science of medicine, must be completed before one can go on with the art of medicine. In certain cases patients are undernourished because of too much rather than too little treatment. I have seen patients continued on special diets until they have lost weight, as well as strength and courage, and they, are "depleted."

In all these cases the doctor must treat the patient first, and then take care of the asthma later.

A new thought has come up within the last two years: Dr. Hans Selye of Montreal has described what he terms "the general adaptation syndrome." He points out that the shock which develops after trauma, after infection, or after an emotional disturbance has certain symptoms — low blood pressure, rapid pulse, sweating, and more or less collapse — which in the normal person pass off in a short time.

There are other people, however, and this is the interesting conception, who continue in this shock state more or less indefinitely for days or weeks or months. Dr. Selye's investigation so far suggests that the difficulty depends upon a disturbance in the function of the adrenal cortex. In treating animals with one of the hormones derived from the adrenal, he has been able to reproduce a symptom complex which is somewhat similar to what happens after the shock of injury in normal people.

He has reproduced the changes which are found after burns or other injuries. Some of the lesions which result are comparable to what one sees in arthritis, and what one sees in asthma. Selye's conception interests me for it encourages the idea that "depletion" is, after all, a reasonable working principle.

Polypoid sinusitis is a separate heading for it represents an important problem; it embraces a very typical characteristic group of patients who are all hard to deal with.

Many patients with chronic severe asthma have had operations on the nasal sinuses. The operation did good for a little while, maybe weeks, but after that the asthma recurs, and when it recurs, it is apt to be worse than before the sinus operation was performed. I am very slow to sanction any further operative procedures on the patient, except for the simple removal of nasal polyps.

Emphysema is interesting: the more one works on it, the less one knows about it. There are various designations for emphysema, but there are only two good ones; functional and structural.

All patients with asthma have functional emphysema during the attack, but, only a very few, something like 2 per cent, have evidence of any structural emphysema. There is a group of older people, and men more than women, who develop what often looks to be primary emphysema. The patient does not have heart disease. The interesting thing is that he sleeps all right, whereas asthma patients do not sleep well. His shortness of breath and his wheeze depend upon a structural defect of the lungs.

Tumors and foreign bodies must always be considered and I would like to tell you a little story.

I was called to the country sometime ago to see an old lady. On the way to the house, the doctor was very much disturbed to find that my bag was so small. He asked, "You didn't bring any skin tests?"

"No," I said, "I came to see what this was all about first. I will come again, if necessary."

He said, "I am sorry; I was kind of hoping that you would find something with your skin test."

A little old lady about sixty-five years old and about sixty-five pounds in weight was sitting in a tremendous chair, before the open fire in the farmhouse, and she was breathing with great difficulty. Her wheeze was obviously a different wheeze than one hears in the ordinary patient with asthma. It was high-up like a croup in a child.

At the end of the first minute, I blurted out: "She has an obstruction between the Adam's apple and the bifurcation of the trachea."

She had been sick only for three or four months, and had lost her weight during that time.

In the hospital the House Officer put a laryngeal mirror in the back of her throat, and demonstrated easily a cauliflower-like tumor between the chords. Subsequently, the cancer was removed through a trachectomy incision. The wheeze disappeared at once and in the seven years since operation the lady has gained fifty pounds in weight, and today she is well. The point in the story was the deep desire of the family doctor for skin tests. He did not realize that "All is not allergy that wheezes."

Now I want to go back and touch very briefly on some of our problems. The symptoms of allergic asthma depend upon the release of histamine in the tissues as a result of the antigen—antibody reaction. Infectious processes and toxic reactions can initiate a similar mechanism and that is understandable, but what about "depletion" and the psycho-somatic factors which are so hard to define? Do they also release histamine and cause symptoms in the same way? Yes! There is evidence that this may happen but this evidence is not too clear and the problem is still open. It is not worthwhile to review it here.

Other problems concern the complications or the accompaniments of severe asthma. *Loeffer's syndrome* with its transient consolidation in the lung as shown by X-ray occurs not too infrequently. Perhaps it does depend upon the total occlusion of one or other bronchus by sticky exudate and the collapse of that portion of the lung supplied by that bronchus. The mechanism is not sure, patients do not die with Loeffers syndrome. The shadows are transient and the reason for them is still doubtful.

Periarteritis Nodosa is another complication. In a group of fifty patients with severe asthma who died, the lesions of periarteritis nodosa were found in five, and that is 10 per cent and a significant figure. For the moment, periarteritis nodosa may be regarded as a special type of pathology which is caused by injury to the blood vessels by some special poisonous factor inherent in severe asthma. It is not uncommon in patients who have received large doses of the sulfonamide drugs. It is rather curious that we do not see periarteritis nodosa nowadays in 1947 as often as we used to see it five or six years ago.

In working on our cases we have always leaned heavily on a study of end results. If the patient was "cured" (in quotation marks) we have tried to find the reason for "cure." Support for the "depletion" theory comes in large part from the end results. Our tabulation shows that many cases have been "cured" without any reference to allergy in the ordinary sense. Potassium iodide, vaccines and diets have been responsible in certain cases. The removal of bad teeth, of infected gall bladders, or prostates has "cured" others. What interests us particularly is the group in which asthma was "cured" by methods which must be called "psychic." The divorce was finally arranged; the job was shifted; a daily exercise in the open air was insisted upon and then more important the patient was made to understand the nature of the asthma and the methods of its control. Confidence and hope took the place of fear and discouragement. The results alone demonstrate not only the importance of "intrinsic" as opposed to "extrinsic" asthma but also the importance of "depletion" as a potent cause. The results demonstrate the corollary that the care of the patient may be of far greater importance than the treatment of his or her asthma.

What about the question?—Is asthma a symptom or a disease? It is probably both. One must recognize that the typical picture of asthma can derive from a great variety of causes, of which allergy is one. This author is not convinced that in the group which he calls "intrinsic," that allergy plays a part. The theories concerning hypersensitiveness to bacteria and the products of their growth and the newer theory that this group of patients have become sensitive to products of very simple chemical structure — asperin sensitiveness gives the clue — are interesting and perhaps the proponents will be able to find support for their claims. Then it will be much easier to bring the "young lady" and the "old gentleman" together. For the moment, however, the contrast between them is so striking that it is best to consider them separately. The problem is far from being solved.

263 Beacon St., Boston, Mass.

SOCIAL WORK IN THE AGED*

MALFORD W. THEWLIS, M.D.

The Author. *Malford W. Thewlis, M.D., of Wakefield, R. I. Associate Editor, GERIATRICS; Secretary, American Geriatrics Society.*

On the morning of the St. Mihiel drive in World War I, I noticed that the French who had been released from bondage of the Germans, were filling the roads, making it difficult for military equipment to move on. There were old men and women as well as younger people. The older ones were headed back home; the young were moving towards Paris. But what was left of their homes was only a few stones and a cellar full of rubble. This was symbolic, however, for even though their homes were destroyed, the earth was still there and that was their home. And on these stones, new homes were begun almost immediately. I understand that the same thing is happening today in Europe.

Several years ago, a London dentist was reading my book and decided to spend his last days under my care. He came to New York; then, in summer, he went to his birthplace in Maine.

This is typical of older people; they want to get back to their homes no matter how humble they may be. This may give a clue to the mentality of the older person and to the younger person who, during prosperous years, would like to give the old folks something better than they rated in their younger years. But home is home to them and one must be careful not to disturb the old person's habits. Moreover, one must remember that old people do not stand drastic changes of any kind.

The fact that older people want their own homes should be considered when one feels forced to separate elderly couples. They should not be kept apart unless mental illness requires a separation. Many old people die soon after they are separated. Sometimes I see children splitting up their relatives with one taking the father and another child taking the mother. This seldom works out well and usually causes mental suffering. The fights of children's families as to what shall be done with their elderly relatives sometimes makes a physician and social worker shudder. We see families at their lowest levels. On the other hand, there are some children who are so attached to their parents that they nurse them in the same way their parents nursed them in their infancy. It is known that psychologically the State becomes the mother or father after the death of a parent one is very fond of passes on, or even before.

What to Do with the Aged

Great advances have been made in social work and the aged in the past few years. The work of Dr. Lilien Martin of San Francisco in rehabilitating the aged person is well known. Perhaps one of the most constructive things we have had is the case work of elderly persons by social workers.

Another important advance in the care of the aged is the community centers for old people, such as the William Hodson Community Center in the Bronx, New York. There are a great many old people in New York City who live alone in furnished rooms who have no companions. Many of these people have creative skills which require employment. At this center older people have a chance to exhibit their leadership. The foundation depends on the fact that mental and physical deterioration seen so frequently in old age is due in great part to psychological results of isolation.

In developing the personalities of older persons, the community center attempts to give meaning and value to living and to produce mutual understanding and appreciation among old people.

The program includes arts and crafts, music, literature, self-government, trips, lectures, parties and games, refreshments, individual counseling.

This center has solved a great problem in New York City and it is hoped that this work will be extended. Why not attempt something of the kind in Rhode Island? It could be started in a small way in a small town or in a city. It could be supported partially by selling some of the products made by older people. These might include toys, dolls, furniture, rugs, knitted products, and other things. Certainly there is a good market for dolls and for a doll repair shop. Surely some department stores would take their products on a commission basis.

*Presented at the Annual Meeting of the Rhode Island Conference of Social Work, at R. I. State College, Kingston, R. I., June 13, 1947.

One of the important things in older people is to keep them working at something which is constructive. Since the war is over, there will be fewer jobs for the elderly and some plans like the ones mentioned may be the solution to their occupation.

While it is a good thing to amuse old people with dominoes and ping pong, why not concentrate on improving their minds and bodies? Lectures, wood craft, any hobby which requires skill would give the old person something to look forward to the next day. For when the next day comes the average old person has little to think about. It is just another boring day, that's all. But if he is making toys or repairing dolls for youngsters, he is really contributing something of value. Besides, nothing causes degeneration in the aged more than inactivity. They should wear out rather than rust out.

Since the older population is increasing each year and the number of children is diminishing, it will be necessary to make older people more efficient so that the State will not be called upon to give so much help to the elderly.

Problem of Chronic Disease

The treatment of chronic disease has become a great problem since institutions and hospitals are filled to capacity. Where to place the elderly person when healthy or unhealthy is a problem. There are inadequate boarding houses, nursing homes, as well as inadequate housing in general. It is bad enough to take care of the aged when well, to say nothing during illness.

The social worker is handicapped because she has insufficient funds to work with and inadequate facilities. Her ingenuity is taxed at all times especially when dealing with stubborn families who refuse to place their elderly parents in public institutions.

Preventive Medicine

The social worker can be of help to the physician in guiding families in the right direction. Together with Public Health nurses they can do their part in educating the public in medical care. Social case work reveals certain findings which are important for the physician to know. For example, the social worker or public health nurse hears that the patient has a bloody discharge, loss of weight, abdominal pain, pain in the chest on exertion, persistent cough, defective vision, ulcer of the leg, swollen ankles, skin eruption which has existed for over three weeks. These people should be directed to a physician or clinic in the hope that further trouble will be avoided. Many early cases of cancer or tuberculosis can be brought to light by the social worker keeping her eyes open for medical conditions which are often passed up by elderly people. There must be some guiding hand to push these people to physicians. Then the physician must be adequate, too, and not pass the patient by as being old and stating that nothing can be done for him.

Ambulatory Illnesses

A great proportion of illnesses in the aged are of an ambulatory nature and could be treated in a physician's office if he was interested enough in geriatrics to do this work. By treating ambulatory illnesses much hospitalization could be avoided, thus relieving institutional congestion.

At the moment, there are no geriatric clinics where this work can be done but there will be in the future. Moreover, there will be more physicians interested in geriatrics and these younger men could have clinics of their own where ambulatory patients could be treated. If the State is not willing to pay for such services they would lose little by taking care of such patients for the experienced gained would be beneficial.

When a social worker, public health nurse and physician are preventive minded, much can be accomplished in preventive work in the aged. The Indiana State Board of Health has a department of adult hygiene and they are doing excellent work in educational lines for the elderly population. This work should be extended and the social worker is in a strategic position to advance this work under the direction of physicians. Finally, I should like to urge social workers to think of and practice prevention.

DISCUSSION

By E. T. Gale, M.D., of Wakefield, R. I.

The value of social work in the adjustment of elderly people to their health and surroundings has been stressed. The excellent pioneer work in New York, Indiana, and California offers physicians and social workers models from which similar organizations can be established throughout the country. It would be well for everyone to become acquainted with this work.

Every city and town should have community centers for those of advanced age. At present there are only a few clubs in the United States, most of which were formed in the manner that bridge clubs are started. And many of these clubs have a purpose similar to that of bridge clubs. A few, however, have attempted to develop constructive educational and recreational programs. Although each one has had a limited success, no great progress has been made because the defects have not been analyzed and the successes have not been utilized in other communities.

An Elderly Welfare Association of America, similar to the Child Welfare League of America, is urgently needed. Paradoxically, the aged, through past experience, are best fitted for organization and coordination; yet they are the only

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IMPETIGO BOCKHART

Case presented by DR. F. RONCHESE

(Rhode Island Hospital Department of Dermatology, weekly (Monday) cases presentation and conference)

(Discussed by Drs. W. B. Cohen, C. S. Sawyer, B. L. Schiff, A. T. Beck. Pathology by Dr. R. J. Williams, photography by G. E. Mancini, microphotography by A. J. Iorio)

IMPETIGO is said to be derived from the Latin "impétere", to assault. A rather out of proportion term for a non violent disease. Pusey[1] says that the word has been in use since the time of Celsus. This explains the discrepancy. At Celsus time impetigo may have been violent or not have been the present days impetigo at all. Changes of centuries old names is impractical or next to impossible. It is preferable to keep them and mention their origin among historical curiosities.

Staphilococcic (follicular) impetigo, described and separated from the common (vesicular) impetigo contagiosa, in 1887 by Max Bockhart, is an uncommon dermatosis, involving the hair follicles, mostly of the scalp.

A Sutton and Sutton[2] illustration shows a case similar to the present one.

CASE REPORT

"D. P., an apparently healthy 15 years old school boy, born in the United States of Armenian ancestry, tells of having a follicular pustular hemorrhagic eruption of 3 years duration on the upper inner aspect of his right thigh and on the right calf. In the attempt to rid himself of it, 2 years ago he applied tincture of iodine, once, to the quadrangular area which is the site of the present dermatosis (see illustration). Evidently he suffered a severe iodine burn, which left a scarred area and a few sparse hairs. The few remaining hairs are the site of a most severe follicular pustular hemorragic dermatosis, while the rest of his hairy legs is of normal appearance.

The severity of the hemorragic pustulation, keeping the area constantly wet with bloody discharge is quite unusual. A tentative explanation of its resistance to therapy is the lowered local resistance from the iodine burn. Chemical burns are a common occurrence. A follicular stapylococcic impetigo limited to one area, persisting for years, not spreading elsewhere, and with the clinical features as illustrated is a rare occurrence.

The urine and the blood were normal.

A smear with the material from a follicular content showed no organisms. Aero-anaerobic cultures from the same material showed stapylococcus aureous coagulase positive.

A biopsy was reported as follows: There is acanthosis with elongation of rete pegs of the epidermis. Beneath this is a discrete focus of granulation tissue which forms an elevated nodule. It shows a massive infiltration by polymorphonuclears and a moderate number of plasma cells and lymphocytes. Cross section of a shaft of hair is present in its depths. The histology is consistent with Bockhart's impetigo and the inflammation is centered in a hair follicle. Diagnosis: Chronic suppurative folliculitis of skin.

The treatment consisted in penicillin wet dressings and ointment and roentgen therapy. In about 2 months the condition cleared up nicely."

Summary

A case is reported of uncommon follicular staphylococcic impetigo (Bockhart).

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[1] PUSEY, W. A., The History of Dermatology, C. C. Thomas, 1933, p. 127.

[2] SUTTON, R. L. and SUTTON, R. L., Jr., Diseases of the skin, C. V. Mosby, 10th edition reprinted with emendations, 1942, fig. 851, p. 905.

"HITLER MEDICINE"

At the regular meeting of the Providence Medical Association to be held on Monday, October 6, at the Medical Library, Dr. Cortez F. Enloe, Jr., of New York, will speak on medicine in Germany under the dictatorship of Hitler.



The upper left photo shows the distribution of the lesions. The upper right, the clinical features of the follicular impetigo. The low power microphotograph shows the acanthosis and the massive infiltration by polymorphonuclears, plasma cells and lymphocites, the inflammatory process centered in the hair follicle.

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THE PROBLEM OF ALCOHOLISM

We are publishing an article on problem drinking. It is significant that drinking which originally meant the act of deglutition applied to liquids, now has a secondary meeting as completely accepted as the first, and signifying the use of alcohol as a beverage. The almost universal use of "liquor" is thus acknowledged in our dictionaries.

The article is written by an Ph.D., not an M. D., which suggests the query: is alcoholism primarily a medical problem? There are undoubtedly certain aspects which bring it directly to the physician. Alcoholic gastritis, cirrhosis, neuritis and psychoses must be treated by him. But these are sicknesses developing late in the progress of alcoholism. The campaigners against alcohol would probably consider these a minor part of the whole sad picture. Preventive medicine would do little against these troubles. That requires cooperation and if we had that the whole problem could be controlled.

The extreme hygienists would have man subsist on proteins, carbohydrates, fats, vitamins and minerals as the beasts of the field have demonstrated can be done. But what has moved man away from the beasts and made him "a little lower than the angels" is undoubtedly mixed up inextricably with a departure from that diet. If man is going to use his intellect however inefficiently he demands as a reward that he has his booze, coffee, tea, tobacco, and saturated sweets, all capable of causing him great injury.

Nature works in mysterious ways her wonders to perform. A member of the faculty of Cornell Medical School some years ago started guinea pigs on daily drunks. After so treating some thousands for many generations, a race was developed physically superior to the original group. Apparently the survival of the fittest brought this about.

The Mohammedans who abstain from alcohol have been for centuries a down trodden group. The tough people who inhabit the northern temperate zone drink hard liquor in enormous amounts and dominate the earth. And look what their domination has brought the world to. If man can be taken off his hard liquor and made weaker, gentler, more like the wild beasts, who almost never seek trouble, a better world will result but the problem is sociological, not medical.

We have been handed a report of a survey of doctors made in New Jersey "to ascertain the climate of opinion of doctors as a group to the problem of alcoholism". We must say that it has not served to modify much the above views. The report concludes that doctors consider the alcoholic a nuisance as a patient, that alcoholics receive from doctors largely palliative and temporary physical reconditioning and that doctors recognize that the problem of alcoholism is in part social and psychological as well as medical.

The report also hopefully notes that a large proportion of chronic alcoholics are seen and rec-

ognized as such by doctors, that the average doctor is more interested in the problem than he has been given credit for but he is aware of his limitations and that doctors have hopes for the rehabilitation of many alcoholics. All of which brings us right back to where we were. If the dominant people are to continue to drink, doctors are going to have an increasingly hard job to straighten them out and they are going to improve their technique with the aid of other agencies as psychiatrists, alcoholics anoymous etc. but they are no more capable of decreasing the number of alcoholics than of decreasing the number of war wounds.

THE FELLOWSHIP ROSTER

This issue of the JOURNAL is the membership issue in that it carries the annual roster of Fellows who constitute the Rhode Island Medical Society. Your name on that list is not merely evidence that you belong to the Society because you are a physician practicising in this State. It means far more than that.

It means that you actively support the programs of the Society for the improvement of the health and welfare of the people of Rhode Island. It means that you are active in the preservation of the high standards of medical care for your patients. It means that you are supporting valuable scientific meetings to keep you and your colleagues informed on the latest developments in the science and art of medicine. It means that you desire, individually and through the Society, to aid in the direction of organized medical activities in our cities, the state and the nation.

You have reason to be very proud of your election as a Fellow of the Rhode Island Medical Society, the tenth oldest state medical organization in the country. The Society has had a brilliant history of achievement in the furtherance of medicine and public health, and it is your heritage to accept and to add new chapters to that glorious record.

The contributions of Rhode Island physicians have been world-wide in effect. Dr. Levi Wheaton, a surgeon in the Revolutionary War, and Dr. Joseph Mauran, early Presidents of the Society, led the fight against Asiatic cholera which first appeared in the United States in 1832, and through their untiring efforts and the petitions of the Society the City of Providence became one of the first to have a full time superintendent of health.

Dr. Usher Parsons, president of the Society in 1837-1840, and the only surgeon entrusted with the treatment of the wounded in Commodore Oliver Hazard Perry's famous naval battle at Lake Erie, initiated the movement that finally resulted in the erection of Rhode Island hospital in 1868.

A Newport physician, Dr. Benjamin Waterhouse, introduced vaccination to this country in 1800, and fifty-six years later Dr. Edwin M. Snow made Providence one of the first cities in the world to require vaccination against small pox a qualification for school enrollment.

Long agitation by the Society for a state board of health was finally justified by the Assembly in 1877, and subsequently Rhode Island became the first state in which the health department undertook the work of free examination of sputum for the diagnosis of tuberculosis under the direction of the medical profession. In 1888 the first municipal laboratory was established in Providence, and the Society was instrumental in the first experiments in filtering water by mechanical filtration as an outstanding forward step in sanitation. In 1907 Dr. Charles V. Chapin revolutionized theories of public hygiene to combat disease with such repute that world-wide honors were bestowed upon him for distinguished service to humanity.

These are but highlights. Each decade witnesses the writing of new chapters. Presently leadership has been given to the question of water and air pollution, and to the extension of surgical care for all the people of the state. Success in these efforts will not be swift, nor easy, but it will be attained just as it was in the other struggles over the past 136 years of the Society's history.

Yes, your name on the Fellowship roster means a great deal to the people of Rhode Island.

IMPORTANT MEETINGS AHEAD

October 6—PROVIDENCE MEDICAL ASSOCIATION

October 13-18 — MEDICO-LEGAL CONFERENCE, Harvard Medical School

October 29, 30, 31—N. E. POSTGRADUATE ASSEMBLY, Copley Plaza Hotel, Boston.

January 5-6—Mid-winter meeting, House of Delegates of American Medical Association, at Cleveland

January 7-8—General Scientific Session for General Practitioners, at Cleveland, (Auspices of A M A)

January 31—Centennial Dinner, Providence Medical Association

April 19-23—American College of Physicians, at San Francisco

May 12-13—137th Annual Meeting, R. I. Medical Society

June 21-25 — Annual Meeting, American Medical Association, at Chicago

ROSTER OF FELLOWS
of the
RHODE ISLAND MEDICAL SOCIETY
SEPTEMBER 1, 1947

Where District Society is not listed after the name the Fellow is a member of the Providence Medical Association.

Telephone numbers have been checked with the latest available directories and every effort has been made to insure accuracy.

Any errors in this listing should be reported immediately to the Executive Office of the Society for correction and special listing in the October issue of the JOURNAL.

A

Abbate, Rocco, 803 Warwick Avenue, Lakewood — HO 3323
Adams, Frank M., 122 Waterman Street, Providence 6 — GA 4183
Adelman, Maurice, 209 Angell Street, Providence 6 — DE 9129
Adelson, Samuel, *(Newport)* 135 Touro Street, Newport — Newport 784-W
Agnelli, Freeman B., *(Washington)* 25 Elm Street, Westerly — Westerly 2507
Alexander, George H., Butler Hospital, Providence 6 — GA 3456
Allen, Reginald A., 223 Thayer Street, Providence 6 — GA 5552, GA 1600
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Angelone, C. Thomas, 872 Park Avenue, Cranston 10 — HO 3900
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Arlen, Richard S., 359 Broad Street, Providence 7 — DE 8210
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Ashworth, Charles J., 184 Angell Street, Providence 6 — GA 4370
Astle, Christopher J., 278 Broad Street, Providence 7 — GA 3167

B

Badway, Joseph M., 549 Broadway, Providence 9 — UN 2400, GA 1600
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Batchelder, Philip, 129 Waterman Street, Providence 6 — GA 2166
Bates, Reuben C., 122 Waterman Street, Providence 6 — GA 4233
Baute, Joseph A., *(Kent)* 4547 Post Road, East Greenwich — Greenwich 420-W
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Bowles, George E., 155 Thayer Street, Providence 6 ..... DE 1898, GA 1600
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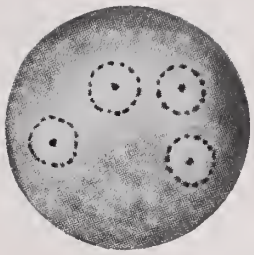
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D

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1. D'Antoni, J. S.: Amebiasis, Recent Concepts of Its Prevalence, Symptomatology, Diagnosis and Treatment, Internat. Clinics 1:100 (March) 1942.

2. Manson-Bahr, P.: Some Tropical Diseases in General Practice, Glasgow, M. J. 27:123 (May) 1946.

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E

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F

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Fracasse, John, 23 Joslin Street, Providence 9
Franklin, Joseph, 217 Elmwood Avenue, Providence 7 — GA 7348
Fratantuono, Frank D., 106 Vinton Street, Providence 9 — PL 4493, PL 9601
Freedman, David, 224 Thayer Street, Providence 6 — DE 0042
Freedman, Stanley S., 183 Waterman Street, Providence 6 — DE 8447
Fruggiero, Enzo J., 68 Beaufort Street, Providence 8 — WE 4536-R
Frumson, Solomon L., *(Woonsocket)* Monument Square, Woonsocket — Woonsocket 719-R
Fuhrmann, Louis J., 933 Chalkstone Avenue, Providence 8 — PL 4539
Fulton, Frank T., 124 Waterman Street, Providence 6 — GA 3111
Fulton, Marshall, 124 Waterman Street, Providence 6 — GA 3111

G

Gale, Elmer T., *(Washington)* 26 Yost Avenue, Wakefield — Narragansett 800-W
Gallagher, Henry J., 386 Smith Street, Providence 8 — DE 5967
Gannon, Charles H., 677 Broad Street, Providence 7 — GA 2280
Garrard, Robert L., Charles V. Chapin Hospital, Providence 8 — DE 7400
Garrigues, Henry B., *(Woonsocket)* 38 Hamlet Avenue, Woonsocket
Garrison, Norman S., *(Woonsocket)* 38 Hamlet Avenue, Woonsocket — Woonsocket 2067
Garside, Francis V., 154 Francis Street, Providence 3 — DE 7572, GA 1600
Gaudet, Albert J., *(Pawtucket)* 592 Smithfield Avenue, Pawtucket — PE 2383
Gauthier, Henri E., *(Woonsocket)* 34 Hamlet Avenue, Woonsocket — Woonsocket 393-W-325
Gerber, Isaac, 10 Leicester Way, Pawtucket — PL 7353
Geremia, Albert E., 172 Pocasset Avenue, Providence 9 — WE 8136
Gershman, Isadore, 343 Thayer Street, Providence 6 — GA 1551
Giannini, Pio, 446 Broadway, Providence 9 — UN 3860
Gibson, J. Merrill, 185 Angell Street, Providence 6 — UN 1243
Gilbert, John J., 209 Angell Street, Providence 6 — GA 1584
Giles, William P., 37 South Angell Street, Providence 6 — PL 7677
Gillis, Nora P., 453 Angell Street, Providence 6 — GA 3215
Giura, Arcadie, *(Bristol)* 31 Washington Street, Warren — Warren 0680
Goldberger, Milton, 729 North 6th Avenue, Tucson, Arizona
Goldowsky, Seebert J., 209 Angell Street, Providence 6 — UN 1707
Goldstein, Sidney S., 203 Thayer Street, Providence 6 — DE 5666, GA 1600
Golini, Carlotta N., 371 Broadway, Providence 9 — UN 6603
Gongaware, Hartford P., *(Washington)* 17 Granite Street, Westerly — Westerly 2246
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Granata, Tancredi G., 347 Broadway, Providence 9 ... DE 0281, WE 1671-W
Granger, Eugene N., Pascoag ... Pascoag 80
Greason, Thomas L., Butler Hospital, Providence 6 ... GA 3456
Greenstein, Jacob, 143 Prairie Avenue, Providence 5 ... GA 1969
Gregory, Kalei K., 211 Angell Street, Providence 6 ... DE 2459
Grenolds, Walter J., *(Washington)* 9 Elm Street, Westerly ... Westerly 2772
Grimes, M. Osmond, *(Newport)* 99 Touro Street, Newport ... Newport 2824
Gross, Carl R., 102 Olney Street, Providence 6 ... DE 8620
Grossman, Herman P., 210 Angell Street, Providence 6 ... DE 2433
Grzebien, Stanley T., 681 Smith Street, Providence 8 ... DE 6334
Grzebien, Thomas W., 187 Academy Avenue, Providence 8 ... WE 3061, GA 1600

H

Hacking, Raymond F., 105 Waterman Street, Providence 6 ... GA 1613
Hackman, Edmund T., *(Kent)* 10 Post Road, Warwick ... WI 2883
Hagenow, LeRoy K., *(Kent)* 3166 Post Road, Apponaug ... GReenwood 1224
Hager, Herbert F., 203 Thayer Street, Providence 6 ... GA 0581
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Happ, Linley C., 170 Waterman Street, Providence 6 ... GA 6855
Hardman, Margaret S., 46 Armington Avenue, Providence 8 ... WE 1995
Hardy, Arthur E., 2 Post Road, Pawtuxet ... HO 9212
Harley, Benjamin F., 154 Angell Street, Providence 6 ... GA 0532
Harrington, Peter F., 249 Hope Street, Providence 6 ... DE 2200
Harris, Herbert E., 219 Waterman Street, Providence 6 ... GA 1721
Harrop, Joseph K., *(Kent)* 1097 Main Street, West Warwick ... VAlley 1233
Harvey, N. Darrell, 112 Waterman Street, Providence 6 ... GA 6637
Hascall, Theodore C., 44 Lincoln Avenue, Riverside 15 ... EA 0020
Hathaway, Clifford S., *(Washington)* 38 Lake Street, Wakefield ... Narragansett 640
Haverly, Richard E., 841 Hope Street, Providence 6 ... GA 9825
Hawkes, Charles E., Greenville Avenue, Smithfield ... Centerdale 0718
Hawkins, Joseph F., 197 Waterman Street, Providence 6 ... GA 2552
Hayes, Walter E., 1103 Cranston Street, Cranston ... WE 4480
Hayward, John A., 273 Morris Avenue, Providence 6 ... DE 1142
Healey, James P., *(Pawtucket)* 84 Broad Street, Pawtucket ... BL 1382
Hecker, Harry, *(Pawtucket)* 172 East Avenue, Pawtucket ... PE 1682
Heffernan, Edward V., 148 Brunswick Avenue, Gardiner, Maine
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Henry, Albert C., *(Washington)* West Main Street, Wickford ... Wickford 409
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Hill, Prescott T., 225 Broad Street, Providence 3 ... DE 0191, GA 1600
Hindle, Joseph A., 655 Broad Street, Providence 7 ... DE 6310
Hindle, William V., 655 Broad Street, Providence 7 ... DE 6311
Hodgson, William H., 1874 Broad Street, Cranston 5 ... WI 2522
Hoey, Waldo O., 295 Angell Street, Providence 6 ... PL 1300
Hogan, John P., 655 Broad Street, Providence 7 ... UN 9544
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Houghton, Montafix W., 163 Congdon Street, Providence 6 — DE 4444
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Hubbard, John D., 162 Angell Street, Providence 6 — DE 0626
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I

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Indeglia, Pasquale V., 451 Broadway, Providence 9 — UN 6070
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J

Jackvony, Albert H., 339 Elmwood Avenue, Providence 7 — HO 1141
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Jones, Walter S., 165 Waterman Street, Providence 6 — GA 8551
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Joyce, Henry S., 201 Waterman Avenue, East Providence 14 — EA 4123

K

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Kapnick, Israel, 224 Thayer Street, Providence 6 — GA 3143
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Kay, Maurice N., 183 Waterman Street, Providence 6 — GA 2230
Kechijian, Harry M., 84 Broad Street, Pawtucket — PE 0493
Kechijian, Natalie, *(Pawtucket)* 84 Broad Street, Pawtucket — PE 7420
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Kelley, Jacob S., 153 Smith Street, Providence 8 — DE 6665
Kelly, Earl F., *(Pawtucket)* 21 High Street, Pawtucket — PE 0220-W
Kempker, Adele C., State Hospital, Howard — HO 4700
Kennedy, John A., *(Woonsocket)* 194 Main Street, Woonsocket — Woonsocket 2708 W
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Kiene, Hugh E., 111 Waterman Street, Providence 6 — PL 5759
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Kingman, Lucius C., 76 Waterman Street, Providence 6 — DE 6138, GA 1600
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L

Ladd, Joseph H., *(Washington)* Exeter School, Lafayette — Wickford 4
Lagerquist, A. Lloyd, 73 Willett Avenue, Riverside — EA 4615
Lalonde, Alphonse J., *(Pawtucket)* 458 Armistice Boulevard, Pawtucket — PE 1876
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Landsteiner, Ernest K., 4 George Street, Providence 6 — UN 2630
Langdon, John, 323 Angell Street, Providence 6 — GA 1016
Laskey, Howard G., *(Washington)* Carolina — Carolina 30 Ring 4
Lauter, Maurice W., Emma Pendleton Bradley Home, Riverside 15 — EA 3400
Laurelli, Edmond C., *(Pawtucket)* 188 Main Street, Pawtucket — PE 5451-W
Lawson, Herman A., 454 Angell Street, Providence 6 — PL 2440, GA 1600
Lawton, Anne L., State Infirmary, Howard — HO 3700
Leech, Clifton B., 82 Waterman Street, Providence 6 — GA 5171
Leet, William L., 199 Thayer Street, Providence 6 — UN 1158
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Levy, William S., *(Woonsocket)* 70 Main Street, Woonsocket — Woonsocket 2098-W
Lewis, Luther R., *(Bristol)* 391 Main Street, Warren — Warren 1962
Libby, Harold, 223 Thayer Street, Providence 6 — GA 1868
Lippitt, Louis D., 41 Pocasset Avenue, Providence 9 — WE 3551
Lisbon, Wallace, 928 Smith Street, Providence 8 — WE 4121
Litchman, David, 102 Waterman Street, Providence 6 — UN 1563
Littlefield, Frank B., 199 Thayer Street, Providence 6 — UN 1446
Littleton, Thomas R., 261 Rhodes Street, Providence 5 — DE 7027
Logler, Frank J., *(Newport)* Newport Hospital, Newport — Newport 410
Londergan, James P., 81 Governor Street, Providence 6 — GA 4255
Lord, Robert M., 122 Waterman Street, Providence 6 — GA 2163
Lovering, Edwin F., *(Pawtucket)* 209 Broadway, Pawtucket — PE 0072-W
Luongo, Fedele U., 508 Charles Street, Providence 4 — DE 2867
Lupoli, Alphonse W., *(Kent)* 3291 Post Road, Apponaug — GReenwood 1600-W
Lury, John J., 1424 Broad Street, Providence 5 — HO 3300
Lynch, John P., *(Pawtucket)* 210 Central Avenue, Pawtucket — PE 0168

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MacDonald, William J., Lt. (jg) MC., USNR, Naval Dispensary, N. O. B., Navy 103 c/o FPO New York, New York
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MacLeod, Norman M., 114 Touro Street, Newport — Newport 282
Magill, William H., 116 Waterman Street, Providence 6 — GA 3539
Mahoney, Andrew W., 1404 Westminster Street, Providence 3 — WE 0200
Mahoney, William A., 44 Montague Street, Providence 6 — PL 1094
Maiello, Robert, 299 Broadway, Providence 3 — GA 3377
Malinou, Nathaniel J., 334 Smith Street, Providence 8 — DE 2123
Malone, John M., *(Newport)* 101 Water Street, Portsmouth — Portsmouth 47
Mamos, Photius D., 600 Broad Street, Providence 7 — GA 2853
Mandell, Israel, 50 Oakland Avenue, Providence 8 — GA 2450
Manganaro, Attilio L., *(Washington)* 95 Kingstown Road, Peace Dale — Narragansett 94
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Mara, Earl J., *(Pawtucket)* 260 Lonsdale Avenue, Pawtucket — PE 0883-W
Margossian, Arshag D., 315 Broad Street, Providence 7 — GA 0516
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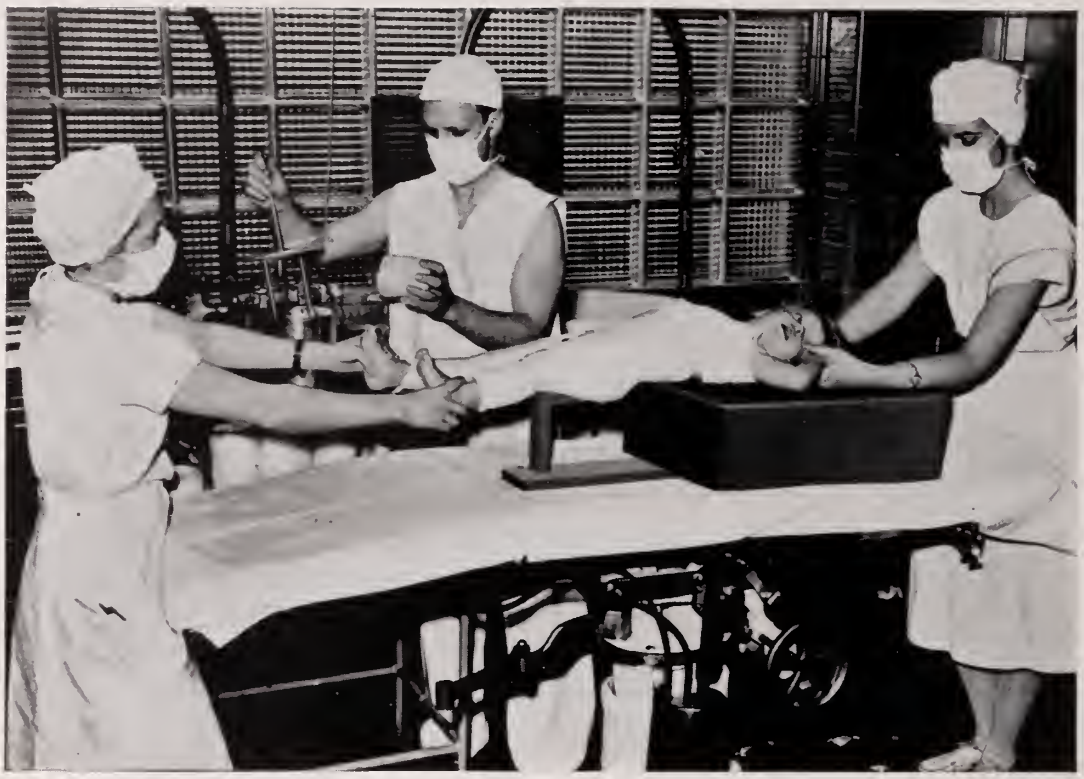
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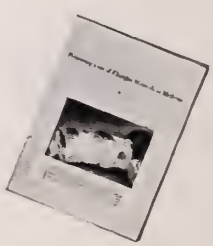
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Martin, Arthur E., 101 Waterman Street, Providence 6 ..... GA 9271
Martin, Richard J., Silk Lane, Scituate ..... Scituate 347, Centerdale 0694-R
Martineau, Lawrence A., Rhode Island Hospital, Providence 2 ..... DE 4300
Marzilli, Alexander F., 7 Dexter Street, Providence 9 ..... WE 3366
Mastrobuono, Amedeo N., *(Washington)* Exeter School, Lafayette ..... Wickford 4
Mathews, Frank H., 382 Brook Street, Providence 6 ..... GA 1815
Mathews, George S., 114 Brown Street, Providence 6 ..... DE 6742
Mathewson, Earl J., *(Pawtucket)* 20 Park Place, Pawtucket ..... PE 6898
Matteo, Frank I., 463 Broadway, Providence 9 ..... UN 3111
Mattera, Vincent J., 425 Broadway, Providence 9 ..... UN 2526
Maynard, Irene G., *(Kent)* 40 Curson Street, West Warwick ..... VAlley 1305
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Mayner, Frank A., *(Newport)* Newport Hospital, Newport ..... Newport 410
McAteer, Raymond F., *(Washington)* 1880 Broad Street, Cranston 5 ..... WI 6565, GA 1600
McCabe, Francis J., 204 Angell Street, Providence 6 ..... PL 3675
McCaffrey, James P., 116 Waterman Street, Providence 6 ..... GA 6533, GA 1600
McCann, James A., 207 Waterman Street, Providence 6 ..... GA 1862
McCarthy, James M., *(Woonsocket)* 426 Blackstone Street, Woonsocket ..... Woonsocket 44-W
McCaughey, Edward H., *(Pawtucket)* 118 Prospect Street, Pawtucket ..... PE 7660-W
McCoart, Richard F., Jr., 30 Olneyville Square, Providence 9 ..... WE 2099
McCooey, James H., *(Woonsocket)* 99 Main Street, Woonsocket ..... Woonsocket 1747
McGurdy, Gordon J., Box 266, Hollywood, Florida
McCusker, Henry F., 167 Angell Street, Providence 6 ..... DE 4901, GA 1600
McDonald, Charles A., 106 Waterman Street, Providence 6 ..... GA 1711
McDonnell, William A., 99 Arlington Street, Brighton, Massachusetts
McEvoy, Frank E., 230 Thayer Street, Providence 6 ..... GA 0578
McGinn, James F. *(Pawtucket)* 1 North Union Street, Pawtucket ..... PE 0277-W
McGovern, Llewellyn J., 1326 Eddy Street, Providence 5 ..... HO 2125, WI 9009
McIntyre, William A., 475 Elmwood Avenue, Providence 7 ..... WI 6500, GA 1600
McKendry, James R., 568 Hope Street, Providence 6 ..... GA 3272
McKenna, Joseph B., *(Woonsocket)* 162 Main Street, Woonsocket ..... Woonsocket 214-W
McLaughlin, Edward A., 600 Broad Street, Providence 7 ..... DE 7470
McLaughlin, William H., *(No district society)* 462 Benefit Street, Providence 3 ..... GA 5787
McOsker, Thomas C., 142 Francis Street, Providence 3 ..... GA 1243
McWilliams, Joseph G., 154 Angell Street, Providence 6 ..... GA 4488
Medoff, Edward B., *(Woonsocket)* Room 204, Hospital Trust Building, Woonsocket
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Mellone, John A., 15 Bay Spring Avenue, West Barrington ..... WArren 0682
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Melvin, Edward G., 369 Broad Street, Providence 7 ..... DE 1018
Menzies, Gordon E., 154 West Main Street, Wickford ..... Wickford 230
Merchant, Marcius H., *(Bristol)* 390 Main Street, Warren ..... WArren 0077
Merlino, Frank A., 377 Hope Street, Providence 6 ..... GA 6745
Merrill, Whitman, *(Kent)* 303 Main Street, Washington ..... VAlley 0881
Messinger, Harry C., 210 Angell Street, Providence 6 ..... GA 3028
Metcalf, Cecil J., 198 Angell Street, Providence 6 ..... UN 0494
Migliaccio, Anthony V., 196 Broadway, Providence 3 ..... GA 4341
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Miller, Henry, 180 Wayland Avenue, Providence 6 ..... UN 0832
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Mills, Parker, 266 Smith Street, Providence 8 ..... GA 1388
Miner, Harold C., 1447 Broad Street, Providence 5 ..... HO 2141
Missirlian, Mihran, 194 Broad Street, Providence 3 ..... GA 5842
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Molony, Walter J., 715 Broad Street, Providence 7 ..... WI 1423, GA 1600
Monahan, John T., 160 Academy Avenue, Providence 8 ..... WE 0218

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Monti, Emilio J., 214 Broadway, Providence 3 ..... GA 4239
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Moor, Henry B., 147 Angell Street, Providence 6 ..... GA 3007
Moore, James S., 30 John Street, East Providence 14 ..... EA 2074
Moran, James B., 452 Manton Avenue, Providence 9 ..... WE 1163
Morein, Samuel, 345 Angell Street, Providence 6 ..... GA 0970
Mori, Laurence A., 55 Pocasset Avenue, Providence 9 ..... WE 2165
Morrone, Louis A., *(Washington)* 115 High Street, Westerly ..... Westerly 2234
Motta, Gustavo A., 164 Academy Avenue, Providence 8 ..... WE 5554
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Mulvey, William A., 24 Beach Road, Bass Rocks, Gloucester, Massachusetts
Muncy, William M., 162 Angell Street, Providence 6 ..... GA 4385
Murphy, John F., 289 Angell Street, Providence 6 ..... GA 0455
Murphy, Robert G., 184 Angell Street, Providence 6 ..... DE 3424, PL 1923
Murphy, Thomas H., 1008 Smith Street, Providence 8 ..... WE 1256
Myers, Edward L., *(Woonsocket)* 56 Winter Street, Woonsocket ..... Woonsocket 266
Myrick, John C., 513 Cranston Street, Providence 7 ..... WE 3762

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Nerone, William S., 21 Bullocks Point Avenue, East Providence 15 ..... EA 4462
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Nourie, Joseph P., 1339 Smith Street, Centerdale ..... CE 0065-W
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O

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O'Brien, John H., 95 Taunton Avenue, East Providence ..... EA 0092
O'Brien, William B., State Sanatorium, Wallum Lake ..... Pascoag 22
O'Connell, Francis D., 215 Thayer Street, Providence 6 ..... GA 1441
O'Connell, Joseph C., 215 Thayer Street, Providence 6 ..... GA 9046
O'Connell, Thomas L., 359 Broad Street, Providence 7 ..... GA 3321, DE 1126
O'Connell, William J., 198 Angell Street, Providence 6 ..... GA 1423, GA 1600
O'Connor, John V., *(Woonsocket)* 162 Main Street, Woonsocket ..... Woonsocket 2540
O'Connor, Michael J., 105 Waterman Street, Providence 6 ..... GA 0935
Oddo, Vincent J., 322 Broadway, Providence 9 ..... GA 1461
O'Donnell, Alan E., 21 Elmgrove Avenue, Providence 6 ..... GA 0549
O'Reilly, Edwin B., 737 Smith Street, Providence 8 ..... DE 1132
O'Rourke, Patrick I., 60 Academy Avenue, Providence 8 ..... WE 2748

P

Pahigian, Vahey M., 49 Villa Avenue, Edgewood 5 ..... HO 6249
Palmer, William H., 59 Elmwood Avenue, Providence 7 ..... GA 4328
Palumbo, Joseph A., 118 Pocasset Avenue, Providence 9 ..... WE 2371
Pardee, Katherine, State Sanatorium, Wallum Lake ..... Pascoag 22
Parkinson, James M., 497 Hope Street, Providence 6 ..... PL 3017
Partridge, Herbert G., 190 Angell Street, Providence 6 ..... GA 5544
Paterson, John A., Veterans Administration Hospital, Togus, Maine
Pearson, Rudolph W., 300 Thayer Street, Providence 6 ..... UN 2224
Pedorella, Americo J., 242 Broadway, Providence 3 ..... GA 8218
Pelletier, Emery, 505 Elmwood Avenue, Providence 7 ..... HO 3141
Penington, Robert, Jr., U. S. Naval Academy, Annapolis, Maryland
Perkins, Jay, 272 Morris Avenue, Providence 6 ..... GA 0551
Perry, Charles F., *(No district society)* High Street, Block Island ..... Block Island 39
Petrucci, Ralph J., *(Bristol)* 88 Child Street, Warren ..... WArren 1121

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*Lehr, D.: Proc. Soc. Exper. Biol. & Med. *58*:11 (Jan.) 1945

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Phillips, Charles L., 294 Main Street, East Greenwich ..... Greenwich 175-W
Pianka, Wallace J., U. S. Veterans Hospital Annex, Vancouver, Washington
Pickles, Wilfred, 184 Waterman Street, Providence 6 ..... GA 1228, GA 1600
Pinckney, John L., 100 North Main Street, Providence 3 ..... DE 0562
Pitts, Herman C., 68 Brown Street, Providence 6 ..... GA 4121
Platt, Marden G., *(Pawtucket)* 123 Massasoit Avenue, Barrington 14, WArren 0414, EA 3836
Porter, Arnold, Children's Hospital, Boston, Massachusetts
Porter, Emery M., 454 Angell Street, Providence 6 ..... PL 2440, GA 1600
Porter, Lewis B., 199 Thayer Street, Providence 6 ..... GA 3970
Portnoy, Bradford M. S., 672 Broad Street, Providence 7 ..... GA 4235
Potter, Alfred L., 171 Angell Street, Providence 6 ..... DE 3241, GA 1600
Potter, Charles, 223 Thayer Street, Providence 6 ..... DE 1311
Potter, Edgar S., *(Woonsocket)* Chepachet ..... Pascoag 124
Potter, Henry B., *(Washington)* Wakefield ..... Narragansett 123
Potter, Merle M., 224 Thayer Street, Providence 6 ..... GA 9184
Potter, Walter H., 68 Jackson Street, Providence 3 ..... GA 4476
Pournaras, Nicholas A., 327 Elmwood Avenue, Providence 7 ..... WI 3022
Pozzi, Gustave, 209 Waterman Avenue, East Providence 14 ..... EA 0330
Prior, James H., 1738 Broad Street, Edgewood 5 ..... HO 1414
Pritzker, Samuel, 179 Wheeler Avenue, Providence 5 ..... UN 0070, WI 7373
Putnam, Helen C., *(No district society)* 312 Laurel Avenue, Providence 6 ..... PL 4059

Q

Quesnel, Ernest, State Hospital, Howard ..... HO 4700

R

Rakatansky, Nathan S., 51 Beacon Circle, Cranston 10 ..... WI 8788
Ramos, Jose M., *(Newport)* 28 Kay Street, Newport ..... Newport 85
Randall, Arthur G., *(No district society)* 511 Westminster Street, Providence 3 ..... GA 2614
Rapoport, Bernard, 169 Waterman Street, Providence 6 ..... DE 1934
Rattenni, Arthur, 1011 Smith Street, Providence 8 ..... WE 6327
Reeves, James A., 1404 Broad Street, Providence 5 ..... HO 2224, GA 1600
Regan, John F., State Hospital for Mental Diseases, Howard ..... HO 4700
Rego, Rodrigo P. daC., 103 Governor Street, Providence 6 ..... DE 7753
Reich, Jacob, 450 Prairie Avenue, Providence 5 ..... WI 3661
Reid, William A., 81 Roger Williams Avenue, Rumford 16 ..... EA 4648
Reilly, Joseph W., *(Woonsocket)* 113 Main Street, Woonsocket ..... Woonsocket 242-R
Ricci, Edward A., 1985 Smith Street, North Providence 11 ..... CEnterdale 0244
Rice, Richard, *(Newport)* 8 Shangrila Lane, Newport ..... Newport 1219 J
Rice, William O., State Infirmary, Howard ..... HO 3700
Richardson, Ralph D., 68 Brown Street, Providence 6 ..... UN 9056
Riemer, Robert W., Rhode Island Hospital, Providence 2 ..... DE 4300
Riley, Clarence J., 507 Manton Avenue, Providence 9 ..... WE 2300
Ripley, Frederic W., Jr., 167 Angell Street, Providence 6 ..... GA 6431, GA 1600
Rittner, Mark, 533 Elmwood Avenue, Providence 7 ..... WI 5577
Roberts, William H., 448 Hope Street, Providence 6 ..... DE 1535
Robinson, Mildred I., *(Washington)* 115 High Street, Westerly ..... Westerly 2234
Robinson, Nathaniel D., *(Pawtucket)* Apt. 10, Larch Street Veterans Housing, Fox Hills, Staten Island, New York
Robinson, Robert C., 133 Waterman Street, Providence 6 ..... GA 1892
Rocheleau, Walter C., *(Woonsocket)* 38 Hamlet Avenue, Woonsocket ..... Woonsocket 2067
Rogell, David, 1338 North Peck Road, El Monte, California
Rogell, Harold, 1338 North Peck Road, El Monte, California
Rohr, Mary-Elaine J., *(Pawtucket)* 358 Pawtucket Avenue, Pawtucket ..... BL 2425-W
Romano, Anthony, 462 Broadway, Providence 9 ..... UN 3577
Ronchese, Francesco, 170 Waterman Street, Providence 6 ..... GA 3004
Ronne, George E., *(Pawtucket)* 49 Fountain Street, Pawtucket ..... PE 3015
Ross, Florence M., 55 Bluff Avenue, Edgewood Station, Providence 5 ..... WI 7868
Rossi, Matthew W., 784 Park Avenue, Cranston 10 ..... WI 8688
Rossignoli, Vincent P., 201 Broadway, Providence 3 ..... DE 2358

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Roswell, Joseph T., *(Woonsocket)* 50 Providence Street, Woonsocket — Woonsocket 74
Rounds, Albert W., 511 Westminster Street, Providence 3 — GA 2927
Rozzero, Paul J., 176 Webster Avenue, Providence 9 — WE 3344
Ruggles, Arthur H., Butler Hospital, Providence 6 — GA 3456
Ruhmann, Edward F., 1711 Broad Street, Cranston 5 — HO 5523
Ruhmann, Warren H., *(Kent)* 4648 Post Road, East Greenwich — Greenwich 7-W
Ruisi, John E., *(Washington)* 41 Grove Avenue, Westerly — Westerly 2575, 4085
Ruisi, Joseph L. C., *(Washington)* 41 Grove Avenue, Westerly — Westerly 4281
Russell, Amy E., 651 Warren Avenue, East Providence 14 — EA 0090-R
Ryan, J. Frank, 1397 Broad Street, Providence 5 — WI 1232
Ryan, Jerome J., 250 Elmwood Avenue, Providence 7 — JA 3232
Ryan, Vincent J., 198 Angell Street, Providence 6 — GA 4313, GA 1600

S

Sage, Louis A., 122 Waterman Street, Providence 6 — GA 8435
St. Angelo, Joseph A., 1891 Smith Street, North Providence 11 — CEnterdale 0167
Saklad, Elihu, 252 George Street, Providence 6 — GA 0026
Saklad, Meyer, 252 George Street, Providence 6 — GA 0026
Saklad, Sarah M., 153 Morris Avenue, Providence 6 — GA 0477
Sammartino, Agostino, 257 Academy Avenue, Providence 8 — WE 4081-W
Sanborn, Harvey B., 112 Waterman Street, Providence 6 — GA 4253
Sannella, Lee G., 124 Waterman Street, Providence 6 — GA 9433
Sarafian, John C., 593 Broad Street, Providence 7 — DE 1146
Sargent, Francis B., 124 Waterman Street, Providence 6 — GA 4422
Savastano, Americo A., 102 Waterman Street, Providence 6 — GA 4538
Savran, Jack, 295 Angell Street, Providence 6 — PL 2112
Sawyer, Carl D., 184 Waterman Street, Providence 6 — GA 1582
Sawyer, Carl S., 184 Waterman Street, Providence 6 — DE 3355
Sayer, Edmund A., 148 Waterman Street, Providence 6 — PL 0148
Scanlan, Thomas F., 366 Atwells Avenue, Providence 3 — GA 0847
Scanlon, Michael H., *(Washington)* 88 High Street, Westerly — Westerly 2190
Schiff, Bencel L., *(Pawtucket)* 251 Broadway, Pawtucket — BL 3175
Schradieck, Constant E., Roger Williams General Hospital, Providence 8 — GA 1625
Schwab, William J., 616 Hope Street, Providence 6 — DE 1279
Scorpio, Angelo, 236 Broadway, Providence 3 — DE 3333
Scotti, Ciro O., 770 Providence Street, West Warwick — VAlley 0465
Segall, Werner, 3903 W. Cold Spring Lane, Baltimore 15, Maryland
Sellman, Priscilla, 21 Lorimer Avenue, Providence 6 — PL 6234
Seltzer, Bernard B., 300 Pontiac Avenue, Cranston 10 — WI 0094
Seltzer, Edward I., 300 Pontiac Avenue, Cranston 10 — WI 0094
Senerchia, Giovanni *(Kent)* 525 Providence Street, West Warwick — VAlley 0569
Senseman, Laurence A., *(Pawtucket)* 1189 Smithfield Avenue, Lincoln — PE 4484
Sharp, Benjamin S., 339 Thayer Street, Providence 6 — DE 0929
Sharp, Ezra A., 339 Thayer Street, Providence 6 — GA 1751, GA 1600
Shattuck, George L., 150 George Street, Providence 6 — GA 7590
Shaw, Eliot A., c/o North Scituate P. O., Foster
Sheehan, John J., 551 Hope Street, Providence 6 — PL 1214
Sheehan, Linus A., 210 Angell Street, Providence 6 — GA 3028
Sheridan, James J., (Lt., M.C.) *(Pawtucket)* Brooke General Hospital, Fort Sam Houston, Texas
Sheridan, Thomas P., 92 Prospect Street, Pawtucket — PE 4633
Sherman, Bernard I., 1045 Broad Street, Providence 5 — WI 4154
Shields, William P., 221 Thayer Street, Providence 6 — GA 2323, GA 1600
Silver, Caroll M., 155 Angell Street, Providence 6 — UN 2021, GA 3333
Smith, Bruce W., 203 Thayer Street, Providence 6 — GA 2221, GA 1600
Smith, Clara L., 281 Olney Street, Providence 6 — GA 5407
Smith, Daniel A., *(Newport)* 29 Mary Street, Newport — Newport 3950
Smith, Frederick A., *(No district society)* 525 Hope Street, Providence 6 — GA 3395
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Sperber, Perry, 136 Elmwood Avenue, Providence 7 — DE 3620
Spicer, Albert D., *(Washington)* 23 Broad Street, Westerly — Westerly 2561
Sprague, Stanley, *(Pawtucket)* 101 Broadway, Pawtucket — PE 3987-W
Stephens, H. Frederick, 195 Thayer Street, Providence 6 — GA 3867
Stevens, Raymond E., *(Pawtucket)* 398 Greenwood Avenue, Rumford 16 — EA 2508
Stevens, Raymond T., 92 Taunton Avenue, East Providence 14 — EA 3933-W
Stone, E. Franklin, 1509 Westminster Street, Providence 9 — UN 4141, GA 1600
Stone, Ellen A., 280 Waterman Street, Providence 6 — PL 5289
Stone, Eric P., Cushing General Hospital, Framingham, Massachusetts
Stone, Jacob, Mt. Sinai Hospital, 1 East 100th Street, New York, New York
Storrs, Berton W., *(Newport)* Main Road, Portsmouth — Portsmouth 20
Streker, Edward T., 984 Broad Street, Providence 5 — WI 7476
Streker, John F., 903 Broad Street, Providence 7 — WI 1244, WI 1432
Sullivan, James F., *(Pawtucket)* 84 Broad Street, Pawtucket — PE 1832-W
Sullivan, Michael H., *(Newport)* 60 Touro Street, Newport — Newport 508
Sullivan, Ralph V., 1192 Westminster Street, Providence 9 — GA 1002
Sweeney, John W., 624 Elmwood Avenue, Providence 7 — HO 5078
Sweet, Charles F., *(Pawtucket)* 69 Dryden Avenue, Pawtucket — PE 0532
Sweet, Gustaf, 105 Waterman Street, Providence 6 — GA 1979, GA 1600
Sydlowski, Edmund J., 66 Doyle Avenue, Providence 6 — GA 3050

T

Taggart, Fenwick G., 1 Montrose Street, East Greenwich — Greenwich 334
Tanguay, J. Edgar *(Woonsocket)* 281 Harris Avenue, Woonsocket — Woonsocket 440
Tarro, Michael A., 973 Atwells Avenue, Providence 3 — WE 3424
Tartaglino, Alfred M., *(Newport)* 75 Pelham Street, Newport — Newport 4190
Tatum, Julianna R., *(Washington)* 8 Margin Street, Westerly — Westerly 2636
Tefft, Benjamin F., *(Kent)* 185 Washington Street, West Warwick — VAlley 0229
Temple, Francis E., 1527 Warwick Avenue, Hoxsie — BA 1265
Tetreault, Adrien G., *(Pawtucket)* 650 Central Avenue, Pawtucket — PE 6778
Thewlis, Malford W., *(Washington)* 25 Mechanic Street, Wakefield — Narragansett 4
Thompson, Edward R., *(Pawtucket)* 18 Exchange Street, Room 218-220, Pawtucket — BL 0132
Thompson, Edwin G., 68 Pocasset Avenue, Providence 9 — WE 0041
Thompson, Ernest D., 90 Waterman Street, Providence 6 — UN 1115, GA 1600
Thompson, William C., Washington Trust Building, Westerly — Westerly 4770
Tingley, Louisa P., 171 Westminster Street, Providence 3 — GA 5922
Tollefson, George A., *(Newport)* 12 Kay Street, Newport — Newport 6349
Trainor, Edward H., *(Pawtucket)* 69 Walcott Street, Pawtucket — PE 1033
Tremblay, Euclide L., *(Woonsocket)* 66 Hamlet Avenue, Woonsocket — Woonsocket 4477-R
Triedman, Harry, *(Pawtucket)* 33 Cottage Street, Pawtucket — PE 5420-W
Troppoli, Daniel V., 380 Broadway, Providence 9 — UN 3325
Trott, Raymond H., 219 Waterman Street, Providence 6 — PL 0246 (Home)
Tully, William H., Jr., *(Washington)* 32 Lake Street, Wakefield — Narragansett 80
Turco, Salvatore J. P., *(Washington)* 170 High Street, Peace Dale — Narragansett 34
Turkel, Eric F., 199 Thayer Street, Providence 6 — GA 7368
Turner, Charles S., 973 Broad Street, Providence 5 — WI 4114
Turner, Henry E., *(Pawtucket)* 101 Broadway, Pawtucket — PE 0594-W
Turner, Howard K., 199 Thayer Street, Providence 6 — GA 7368, GA 1600
Turner, J. Lincoln,*(Pawtucket)* 101 Broadway, Pawtucket — PE 0594-W
Tweddell, Henry J.,*(Woonsocket)* 115 Cass Street, Woonsocket — Woonsocket 5322

U

Umstead, Howard W., *(Pawtucket)* 188 Main Street, Pawtucket — BL 1924
Utter, Henry E., 122 Waterman Street, Providence 6 — GA 2147

V

Vallone, John J., 270 Elmwood Avenue, Providence 7 — JA 2433
Van Benschoten, George W., 195 Thayer Street, Providence 6 — GA 3867
Vaughn, Arthur H., 137 Warren Avenue, East Providence 14 — EA 1721

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Verrone, Anthony C., 1574 Cranston Street, Cranston 9 ..... UN 0460, GA 3333
Vian, George M., *(Woonsocket)* 308 Stadium Building, Woonsocket ..... Woonsocket 5914-W
Vidal, Jeannette E., *(Kent)* 14 St. John Street, West Warwick ..... VAlley 0544
Vieira, Edwin, 221 Warren Avenue, East Providence 14 ..... EA 2248
Visgilio, Thomas, Jr., *(Woshington)* Room 415, Washington Trust Building, Westerly ..... Westerly 2509
Votta, Paul J., St. Joseph's Hospital, Providence 7 ..... DE 2700

W

Walsh, John G., 221 Thayer Street, Providence 6 ..... GA 1710
Warren, Jacob P., *(Washington)* 59 Elm Street, Westerly ..... Westerly 2616
Waterman, George W., 155 Thayer Street, Providence 6 ..... DE 4229, GA 1600
Webber, Joseph B., 730 Broad Street, Providence 7 ..... HO 5431
Webster, Frederick A., *(Pawtucket)* 70 Greenwood Avenue, Rumford 16 ..... EA 3519
Weigner, Walter C., 131 Waterman Street, Providence 6 ..... DE 5636
Welch, Stephen A., 255 Washington Street, Providence 3 ..... GA 1333
Wells, Guy W., 124 Waterman Street, Providence 6 ..... GA 3111
West, Edward J., Charles V. Chapin Hospital, Providence 8 ..... DE 7400
Westcott, Clinton S., 454 Angell Street, Providence 6 ..... PL 2440
Westcott, Niles, Butler Hospital, Providence 6 ..... GA 3456
Weyler, Henry L. C., 335 Angell Street, Providence 6 ..... GA 0720
Wheaton, James L., *(Powtucket)* 164 Broadway, Pawtucket ..... PE 2102
Whipple, Richard K., 122 Waterman Street, Providence 6 ..... DE 1700
White, George F., 1300 Elmwood Avenue, Cranston 7 ..... WI 3131, GA 1600
Whitmarsh, Robert H., 154 Angell Street, Providence 6 ..... GA 3061, GA 1600
Wilcox, Roswell S., 1374 Eddy Street, Providence 5 ..... WI 4224
Williams, Harold W., 129 Waterman Street, Providence 6 ..... UN 0459, GA 1600
Williams, Pearl, 371 Broad Strcet, Providence 7 ..... GA 1966
Windsberg, Eske, 203 Thayer Street, Providence 6 ..... PL 4343
Wing, Elihu S., 155 Thayer Street, Providence 6 ..... GA 3314
Winkler, Herman A., 224 Thayer Street, Providence 6 ..... GA 4010, GA 1600
Winkler, Malcolm, 199 Thayer Strect, Providence 6 ..... DE 0105, GA 1600
Wise, Bernard O., Valley Forge General Hospital, Phoenixville, Pennsylvania
Wittes, Saul A., *(Woonsocket)* Stadium Building, Woonsocket ..... Woonsocket 5910-W
Wittig, Joseph E., *(Kent)* 331 Washington Street, West Warwick ..... VAlley 0919
Wolfe, Hattie G., State Hospital, Howard ..... HO 4700
Woodcome, Harold A., *(Pawtucket)* 84 Broad Street, Pawtucket ..... BL 2907-W

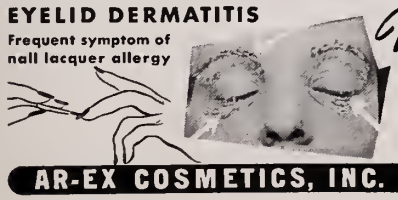
Y

Yessian, Mark A., 184 Elmwood Avenue, Providence 7 ..... DE 6613
Young, Daniel D., 134 Francis Street, Providence 3 ..... GA 7517, GA 3333
Young, George L., *(Kent)* 4640 Post Road, East Greenwich ..... Greenwich 614-W
Young, John A., *(Newport)* 253 Broadway, Newport ..... Newport 956

Z

Zambarano, Ubaldo E., State Sanatorium, Wallum Lake ..... Pascoag 22
Zamil, Edward *(Newport)* 20 Greenough Place, Newport ..... Newport 4898-R
Zecchino, Vincent, 185 Angell Street, Providence 6 ..... UN 9000, GA 1600
Zielinski, Norbert U., *(Newport)* 27 Kay Street, Newport ..... Newport 623
Zimdahl, Walter T., c/o Mr. Raymond Groner, 280 Riverside Drive, Apt. 6B, New York, New York
Zinno, Genarino R., 334 Branch Avenue, Providence 4 ..... GA 6534
Zolmian, Hrad H., *(Pawtucket)* 116 Mineral Spring Avenue, Pawtucket ..... BL 0143
Zouraboff, Catherine, 167 Julia Street, Cranston 10 ..... WI 4485
Zucker, Joseph M., Mental Hygiene Clinic, Veterans Administration, Providence ..... JA 5050
Zurawski, Charles, 30 Olneyville Square, Providence 9 ..... WE 3481-M

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Herman C. Bumpus, Jr. — Herman Carey Bumpus, Yankee Naturalist. Minneapolis, 1947.

Henry F. Howe — Prologue to New England. N. Y., 1943.

Frederick C. Irving — Aesculapius Inspects the Harvard Medical School. (pamphlet)

GYNECOLOGY

Charles F. Geschickter — Diseases of the Breast. 2nd ed. Phil., 1945.

HEMATOLOGY

Edith L. Potter — Rh. Chic., 1947.

Maxwell M. Wintrobe — Clinical Hematology. 2nd ed. rev. Phil., 1946; repr. 1947.

INDUSTRIAL HYGIENE

A Medical Survey of the Bituminous Coal Industry. Wash., 1947.

MEDICINE

Russell L. Cecil, editor — A Text-book of Medicine by American Authors. 7th ed. rev. Phil., 1947.

METABOLISM

Garfield G. Duncan, editor — Diseases of Metabolism. 2nd ed. Phil., 1947.

NEUROLOGY

James C. White & Reginald H. Smithwick — The Autonomic Nervous System. 2nd ed. N. Y., 1946.

NUTRITION

Tom D. Spies — Rehabilitation Through Better Nutrition. Phil., 1947.

OBSTETRICS

Joseph B. DeLee & Jacob P. Greenhill — The Principles and Practice of Obstetrics. 9th ed. Phil., 1947.

ORTHOPEDICS

Frederic W. Bancroft & Clay R. Murray, editors — Surgical Treatment of the Motor-Skeletal System. 2 vols. Phil., 1945.

Charles S. Venable & Walter G. Stuck — The Internal Fixation of Fractures. Springfield, Ill., 1947.

PATHOLOGY

William Boyd — Surgical Pathology. Phil., 1947.

Emil Novak — Gynecological and Obstetrical Pathology. 2nd ed. Phil., 1947.

PHARMACY

New and Nonoffical Remedies. 1947. Chic., 1947.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1946. Chic., 1947.

Gifts

Gifts of books and journals were received from the following: Doctors Russell S. Bray, William P. Buffum and Stephen A. Welch, the Estate of Doctor Harlan P. Abbott and from the American Medical Association.

LIBRARY BUILDING IMPROVEMENTS

With the approval of the Council the Board of Trustees of the Library building have continued the needed improvements to the Society's building that were started a year ago after a careful check of the property had been made by our architects. It will be remembered that last year the roof was completely repaired, the brick walls pointed and made leak proof, and the auditorim repainted

This summer the Board of Trustees, on advice of architect, have replaced the old light fixtures, and authorized the painting of the reading room, the Miller room, the stairways and auxiliary rooms.

Members will undoubtedly note the great improvement of the auditorium where the old hanging lamps have been replaced with fixtures set flush with the ceiling and providing a sealed beam light far superior to that previously available. In addition a master switch has been built in the auditorium balcony to provide for the convenient darkening of the hall at the time of scientific lectures during which lantern slides are used.

The repainting of the reading room, plus new lighting fixtures there, mark major steps in the plans for the improvement of this room. The large conference table has been moved to the basement dining room, and plans now under consideration call for smaller and more useful tables in the reading room for use of physicians doing reference work. New bookshelves are also proposed for the better display of the current medical journals.

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1. Anderson, N. A.: Penn. Med. J., *48*:566-8 (Mar.) 1945

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CERTAIN ASPECTS OF PROBLEM DRINKING

concluded from page 656

for living. All education takes time; man acquires his knowledge slowly. The re-education of a problem drinker can never be successfully brought to fulfillment by negative precepts. But with encouragement and with knowledge, the problem drinker can grow in his attitudes. He can be seen changing, not alone in his living without alcohol, but as well in the way in which he meets each new situation in his life as it arises. If he can be poised when confronted with his troubles, if he can take disappointments as they come, it is obvious that he has grown in maturity and self-wisdom, and the likelihood is greatly increased that in the future he will not have to evade his responsibilities by means of alcohol. If a patient can achieve understanding of the reasons for his abnormal drinking and a perspective on the outer circumstances of his life, the outlook for the remainder of his life is promising.

The therapist can take thought, in the re-education of a problem drinker, to the close of the Hippocratic aphorism: "Life is short, art is long, opportunity fugitive, experimenting dangerous, reasoning difficult; *it is necessary not only to do oneself what is right, but also to be seconded by the patient, by those who attend him, by external circumstances.*"

The patient, too, can well meditate: A problem drinker can never drink again, even in moderation, without getting into difficulties. But he can learn to live and to enjoy life without alcohol. In all therapy, in the entire re-educational process, these two statements are of primary significance. And, whereas the first presents an obstacle to be surmounted by the drinker, the second offers him hope and promise and real reward.

SOCIAL WORK IN THE AGED

concluded from page 661

group of people who do not have a national organization. The young people have health organizations, church clubs, Boy Scouts, Girl Scouts, Fraternities, Y.M.C.A., Y.W.C.A. and various other societies. Besides, most places of entertainment are planned for youth; the aged find little comfort in activities which demand great physical strain. With the exception of bingo centers, which are rapidly becoming congested with old men and women, I cannot think of a single place where elderly couples can go and spend a comfortable and enjoyable evening. On the other hand, I can point out hundreds of places where young people can spend every evening, if they desire.

It will be several years before communities for the aged will be established, but the social workers interested in geriatrics can begin to work toward this goal. They are in frequent contact with large numbers of isolated elderly people, and can bring groups of individuals with common interests together and establish mutual relations. Rhode Island is the smallest state in the Union and has closely associated health and welfare departments; therefore, it is an ideal state for state-wide experiments in social work, and especially with the aging population.

Of course, community centers are only a part of a social program, for economic, educational, psychosomatic, and medical aspects are fundamental in work with the aged.

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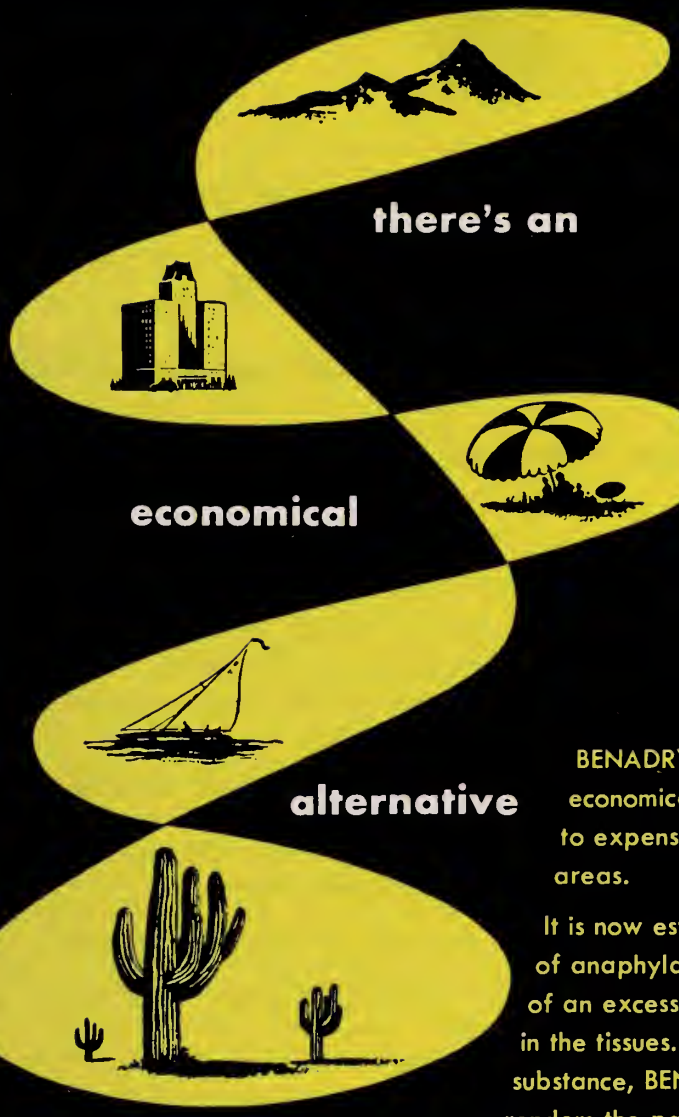
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According to Freed (J. A. M. A., Feb. 8, 1947), "Benzedrine Sulfate . . . is of inestimable value in controlling the desire for food and in reducing the level of satiability to a more normal one. This drug is commonly administered in dosages of 5 mg. three times a day, thirty to sixty minutes before each meal. Occasionally patients will require 10 mg. at one or more times during the day, depending on their response to the drug."

The use of Benzedrine Sulfate alone ordinarily should achieve the desired appetite reduction. Combinations of amphetamine and thyroid serve no useful purpose and may even be dangerous. In this connection, a recent report of the Council (*Drugs for Obesity*, J. A. M. A., June 7, 1947) says: "The fallacy and dangers of overstimulating the body with thyroid and of using laxatives to aid in reduction are well known to the medical profession."

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ORGANIZATIONAL DEVICES TO PROTECT THE PATIENT*

ALEX M. BURGESS, M.D.

(Chief of Medical Department, Rhode Island Hospital; Professor of Medical Sciences, Brown University)

Introduction

The primary purpose of the hospital is to care for the sick and injured. The organization of the hospital staff and every factor that enhances its proper functioning is a means to the same end — the care of the patient. The secondary objective of the hospital, its educational function is again directed to the same end in that better trained, better informed doctors and nurses can give the patient better, more intelligent care. The entire hospital organization then, is devised for the patient's care and protection. Taking this for granted, it is my object to stress, from the point of view of the practicing physician, who has the real responsibility for the medical and surgical care of individual patients, certain aspects and certain details of the organization and of the inter-relations of hospital staff, administration and special departments which bear directly on patient welfare. This will include various customs, regulations and rules as well as the cultivation of attitudes and ideals which have as their object the welfare of the patient and may properly be considered "Organizational Devices" to protect the patient.

Admission and Allocation

First let us consider the admission of the patient to the hospital. The function of the admitting officer is dual. By his examination of the patient himself or of his credentials, by which I mean the information furnished by the referring physician (if one there be) the admitting officer not only protects the hospital from receiving a patient who is not a fit subject for admission to that particular hospital, but he also protects the patient by giving or ordering emergency treatment if indicated, by preventing unnecessary delay in the proper reception of a sick individual and by arranging for his allocation to the proper ward or room and to the care of a properly trained physician or surgeon, as the case may be, whose special knowledge and skill is adequate for dealing with the problem which the patient presents. The organizational device which is used here to protect the patient is the rule, and a very important one it is, which prevents an individual staff member from receiving as a patient a person suffering from a condition in the care of which the doctor in question has not had a sufficient experience and training to be considered an expert. This means the limitation of responsibilities and privileges of staff members to practice in their own specialties, a subject which I shall discuss more fully under Staff Organization. In a small hospital, in a small community, where most of the staff are engaged in general practice this limitation may be relatively slight but it is fair to say that the more the members of the staff specialize and the more strictly they are held in their hospital work to the practice of their specialties, the better will be the grade of work done in that hospital, and the better protection the patients will receive.

Staff Organization

In accordance with this idea the whole organization of the staff into departments is a device for the protection of the patients. The clinical departments, medicine, surgery and the various medical and surgical specialties each should have within itself a division of responsibilities according to its needs. In many large hospitals each department is headed by a chief. Its members rank as visiting or attending physicians or surgeons, and assistant visiting, often of more than one rank or grade. Temporarily attached to and working in each department are the residents and internes. The responsibilities of each visiting or assistant visiting man should be determined by the chief of the department. When it comes to the care of private patients the chief of the department is without direct authority over the work of the visiting men. Unless a regulation of some sort is set up, it becomes quite possible for a visiting man whose enthusiasm or confidence (not to mention other less creditable qualities) tends to be excessive, to undertake treatment, as, for example, difficult surgical procedures, for which he is insufficiently trained. For this reason a competent authority should be set up to appraise the ability and training of in-

continued on next page

* Presented at the Third New England Institute for Hospital Administrators, at Providence, June 24, 1947

dividual staff members and to determine what their privileges in the care of private patients shall be. At the Rhode Island Hospital, for example, this function is performed by the Credentials Committee, a body composed of the chiefs of all departments.

Another matter that bears on the welfare of patients is the definite fixation of responsibility. This, in the case of a private patient, rests, of course, on the doctor to whose care she or he is admitted and can only be shifted to another by means of a formal transfer which must be executed in writing usually by the signing of a printed transfer slip. In the case of the ward patient, the responsibility rests on the senior visiting physician on duty. There must be no doubt whatever about this fact. Neither the chief nor the administration can force him to adopt a course of treatment of which he does not approve nor omit treatment which he chooses to order, unless such treatment definitely conflicts with the rules of the hospital laid down by the administration. The assistant visiting man works under the direction of the visiting man whom, when absent, he represents and whose duties and responsibilities he then assumes. Residents and internes are the representatives of the visiting staff when the latter are not in the hospital, and carry out the treatments ordered. In all cases, however, the ultimate authority rests in the visiting man on duty. The chief of the department, although responsible for the personel and organization of the department and its professional and educational program, does not have authority over the visiting men on duty in the actual treatment of individual patients.

Educational Program

Another phase of the work of the hospital staff that, broadly speaking, may be said to be for the benefit and protection of the patient is the educational program. This is a topic about which a great deal might be said but it cannot be considered as relevant to this discussion which deals with details of organization rather than with its broader aspects.

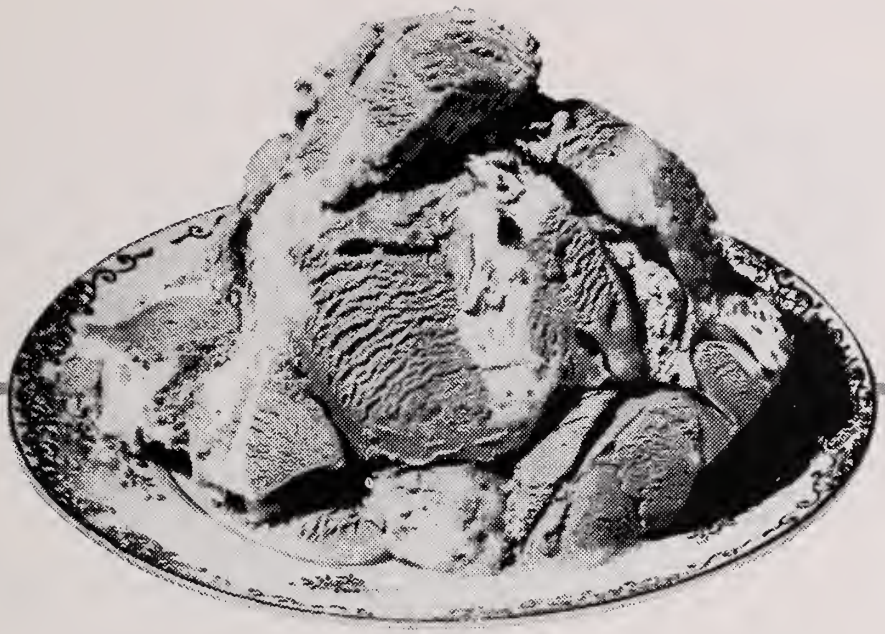
The Nursing Staff

When we consider the duties of the nursing staff in relation to those of the physicians of a hospital we come to a most important topic. Here time-honored tradition and definite regulations both play a part as does the spirit that has been fostered in the individual institution by the leaders of both groups. The physicians give the orders for treatment and the nurses carry them out and are responsible for the comfort of the patient — from minute to minute and hour to hour — a matter of the greatest importance as all of us who have had personal experience with severe illness can testify. In addition to a spirit of perfect cooperation between the medical and nursing staffs it is also necessary that certain definite regulations be set up to make this cooperation actual as well as theoretical. Time does not allow a detailed description of the rules of nursing technique, and such a discussion could not be given adequately except by a member of the nursing profession. From a physician's point of view, however, there are certain details which may well be mentioned. First the matter of writing orders. Orders must be written — for if given orally the nurse cannot be held responsible for a correct understanding of them. Next, they must be written legibly. They must be signed by the physician and the date and hour recorded. The nurse, in turn, must sign her receipt of the order when she has read it, thus recording the fact that she has read the order, understood it, and accepted the responsibility for putting it into effect. Any doubt on her part as to what the order means should lead to an immediate appeal for a correct interpretation. If her superiors in the nursing group cannot clear up her doubts it is necessary for her to go to the doctor who wrote the order for help. It is a neglect of carrying out these simple matters of technique in detail that leads to confusion over orders, perhaps the most common cause of confused and inefficient treatment of patients. In a large ward where many new orders are written every day a convenient device is a "report sheet" on which the doctor writes his name and that of the patient with the time of giving the order, so that the head nurse may tell, almost at a glance, on what patients new orders have been written and thus avoid a tedious search through all the patients' records. A nurse should never be held responsible for carrying out an order that is not properly written with date, time and signature of the doctor.

Isolation and Barrier Technique

Another matter of importance in the protection of the patient is the matter of the isolation of patients with contagious disease. Time does not allow for a detailed discussion of barrier technique. Here in the home of the late Dr. Chapin, who first pointed out the necessity of medical asepsis, there are still many of us who had a part in the early application and development of these principles which are now so well known and universally practiced as to be familiar to us all. I wish, however, to enter a plea for conscientious observance of the rules in this matter. Nothing is more disheartening or tends more to a breakdown of morale than a situation in which the nurse has carefully carried out her technique in dealing with an isolated patient and then the doctor, relying on the fact that no one present has authority to interfere with what he does, comes in and himself carelessly neglects the rules, exposing both himself and the patients whom he will later attend — to the danger of infection. Such things must not be tolerated.

continued on page 698



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ORGANIZATIONAL DEVICES TO PROTECT THE PATIENT

concluded from page 696

Consultations

Another important subject to be discussed in this connection is consultations and transfers. In hospitals as in private practice outside hospitals a physician's real worth can be gauged in part by his readiness to suggest consultations whenever situations arise in the course of his patient's illness which make the advice of another doctor appropriate. In the hospital consultations should be *formal* in that they should result from a definite request on a printed form, they should be, when possible, *personal* — by which I mean carried out with both the consultant and the physician requesting the consultation meeting in person at the bedside, and they should be *prompt*. It should be a matter of pride as well as duty on the part of a service, that it receives no request for a consultation that it does not carry out within twenty-four hours. It is a function of the chief of each service to see that all consultations for which his service receives requests are promptly consummated. And last but not least the consultation must be promptly recorded on the record in the form of a note for which the consulting service is responsible.

In certain situations consultations should be obligatory, because the disease in question by its nature does not fall entirely in the province of a single specialty. For example, peptic ulcer and diseases of the thyroid are both medical and surgical conditions. At the Rhode Island Hospital patients with either of these conditions may be admitted to either the medical or the surgical service but in every case a consultation is required so that the patient may benefit from both medical and surgical judgment. In all consultations, of course, the ultimate decision as to what shall be done rests with the visiting man on whose service the patient is admitted and he can completely disregard the advice of the consultant if, in his judgment, it is best for the patient that he do so.

Records

Another device for the protection of the patient is the hospital record. This must be complete, accurate and up to standard. As has been well said, "Observations unrecorded are lost," and one might add that observations recorded late from memory are inaccurate. It is then the duty of the visiting men and the residents to see that records are promptly and accurately written and of the chief of the department to give this matter his constant attention. On the surgical side the regulation which requires the recording of a history and physical examination before operation is important. Even in an emergency the surgeon should be required to record some pre-operative statement of the patient's condition and the reason for operation. If anyone doubts the value of accurate records in the protection of the patient and his interests he has not had the experience of trying in vain to find out just what was done to his patient on a previous admission to the hospital or of attempting to explain to a judge or jury just what is meant by a hodge-podge of illegible and unintelligible hospital slang on the record of a patient in whose interest he is appearing in court. An adequate record system in charge of trained record librarians is an asset which every hospital will find indispensable.

Discharge

We now come to the discharge of the patient. Here, again, the patient will be protected only if an accurate and complete discharge note is recorded and a copy of this note or a summary of its contents is sent to the doctor or clinic who will be responsible for the patient's future care. No patient should be discharged without an accurate knowledge on the part of the service of the conditions under which he will have to live. This means, in many instances, a social service study — and all patients in whom home conditions are not obviously good must have such a study by trained social workers. A summary of this study should be attached to the patient's record. In the case of patients who cannot afford the services of a private physician definite arrangements for observation in an out-patient department or follow-up clinic should be made.

So much, then, for organization, rules, regulations and "devices" to protect the patient and his interests. It goes without saying that rules and devices are merely mechanical aids. The essential ingredients in the patient's care are the ideals of service and the professional competence of doctor, nurse and administrator. Without such basic qualities in the hospital staff no amount of mechanical regulation will avail and in the presence of the proper spirit of service, professional ability and desire to cooperate, such rules and devices will never become factors of irritation and annoyance but will rather serve as welcome aids in the attainment of the main objective, the welfare of the one person for whom the hospital exists — the patient.

LIBRARY HOURS

With the conclusion of the summer recess the regular Library hours will prevail. Hence, the Library will be open every day but Saturday from 9 a.m. until 5 p.m., and on Saturday from 9 a.m. until noon. Evening hours are from 7 p.m. until 10 p.m. on Tuesday, Wednesday, and Thursday. The building is closed on Sundays and holidays.

AGE and the PERIPHERAL ARTERIES



Arteriosclerosis

"Arteriosclerosis of the arteries of the extremities is an important cause of illness and disability in elderly persons."

— *Boas, E. P.: Treatment of the Patient Past Fifty, Chicago, The Year Book Publishers, Inc.,* 1941, *p.* 122.

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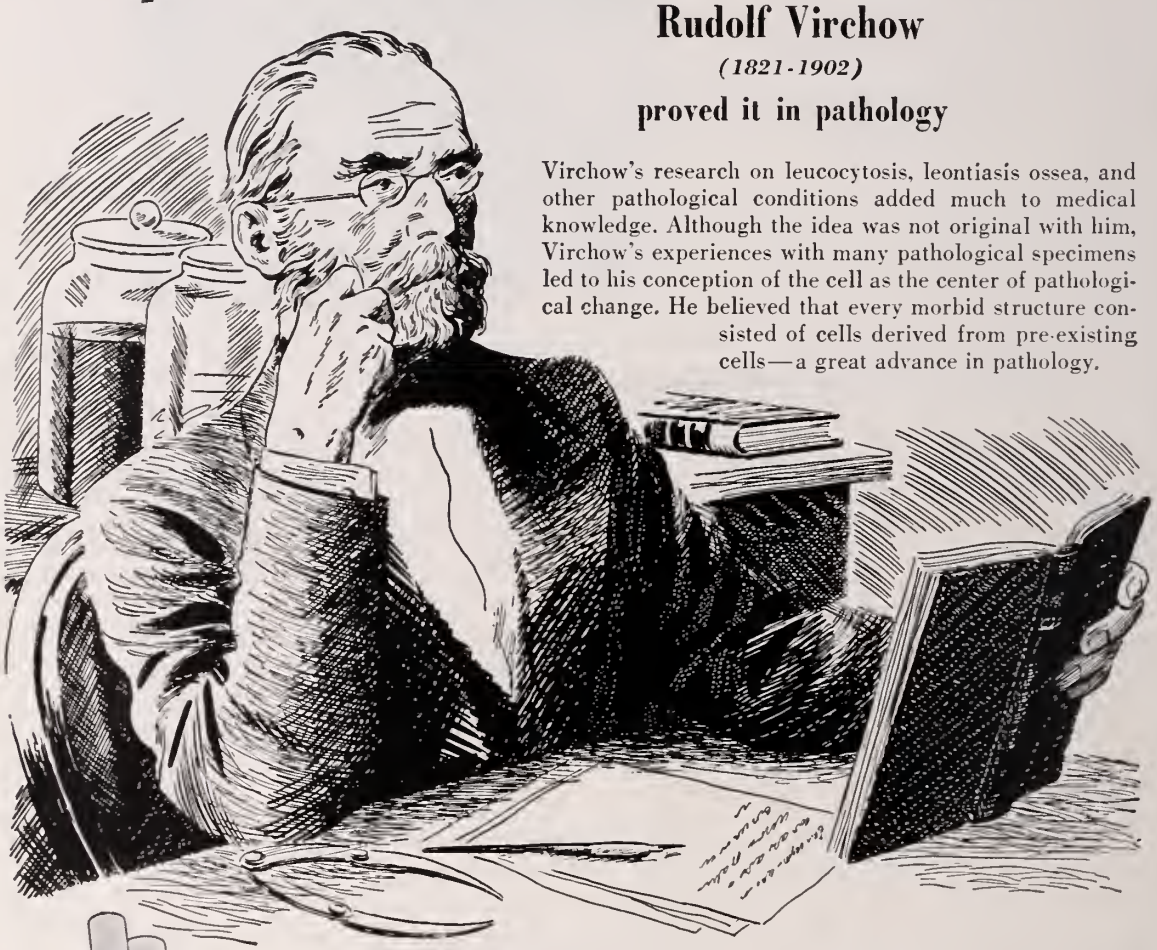
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Rudolf Virchow

(1821-1902)

proved it in pathology

Virchow's research on leucocytosis, leontiasis ossea, and other pathological conditions added much to medical knowledge. Although the idea was not original with him, Virchow's experiences with many pathological specimens led to his conception of the cell as the center of pathological change. He believed that every morbid structure consisted of cells derived from pre-existing cells—a great advance in pathology.

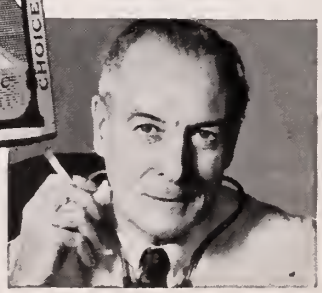




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PHYSICIANS ART ASSOCIATION

THE PUBLICATION in the July issue of this Journal of the prize winning photograph by Dr. F. Ronchese in the Physicians Art Association has evoked inquiries from members relative to this organization. The Physicians Art Association was organized ten years ago under the sponsorship of Mead Johnson & Company of Evansville, Indiana. Held annually at the time of the sessions of the American Medical Association, the exhibition of this Association has become one of the outstanding features of the exhibit hall.

At the recent meeting in Atlantic City there were 1,274 art objects on display, an increase of 563 pieces over last year's show. Included in this year's displays were sixty-three objects from other Western Hemisphere countries. Over 600 physician-artists exhibited, thus indicating the great interest of physicians in art expression, through oil, watercolor, photography, etchings, drawings, ceramics, sculpture, metal work, wood work, and even needle work. The photograph below gives some idea of the varied display of art that was viewed by an estimated 50,000 persons during the week show at Atlantic City.

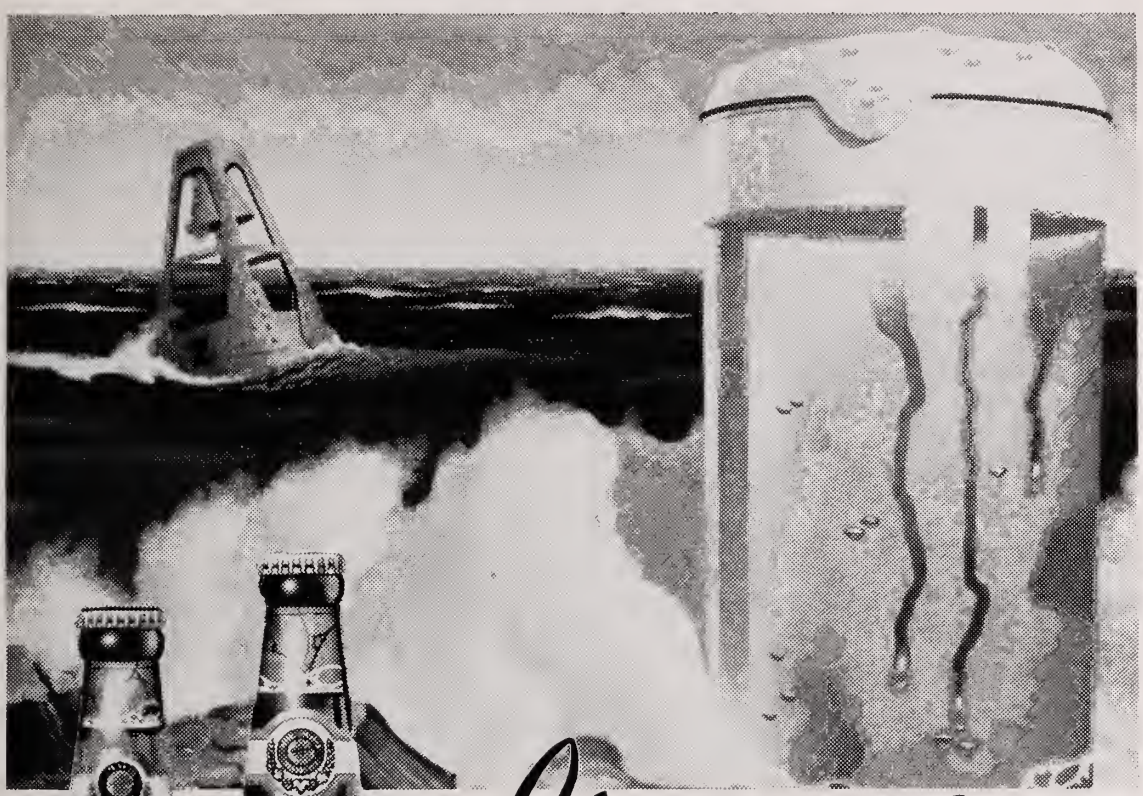
The special feature of the show this year was the competition in the prize contests sponsored by Mead Johnson & Company on the subject of "Courage and Devotion Beyond the Call of Duty" on the part of physicians in war and in peace, for which $34,000 in Savings bonds was offered. Other prizes included cups, medals and certificates.

The American Physicians Art Association numbers about 1,000 active physician-artists and approximately 4,000 other physicians who have affiliate membership. Fellows of the Rhode Island Medical Society interested in the organization are invited to communicate with the Society's executive office. . . . . The Editors.



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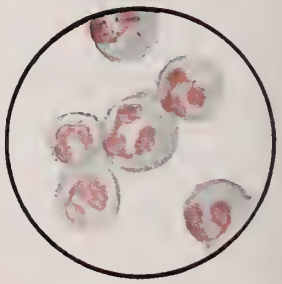
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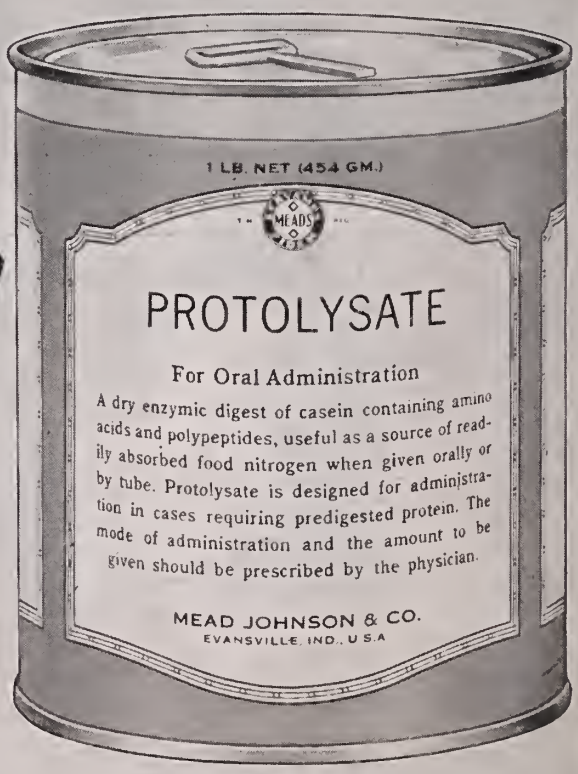
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Volume XXX, No. 10

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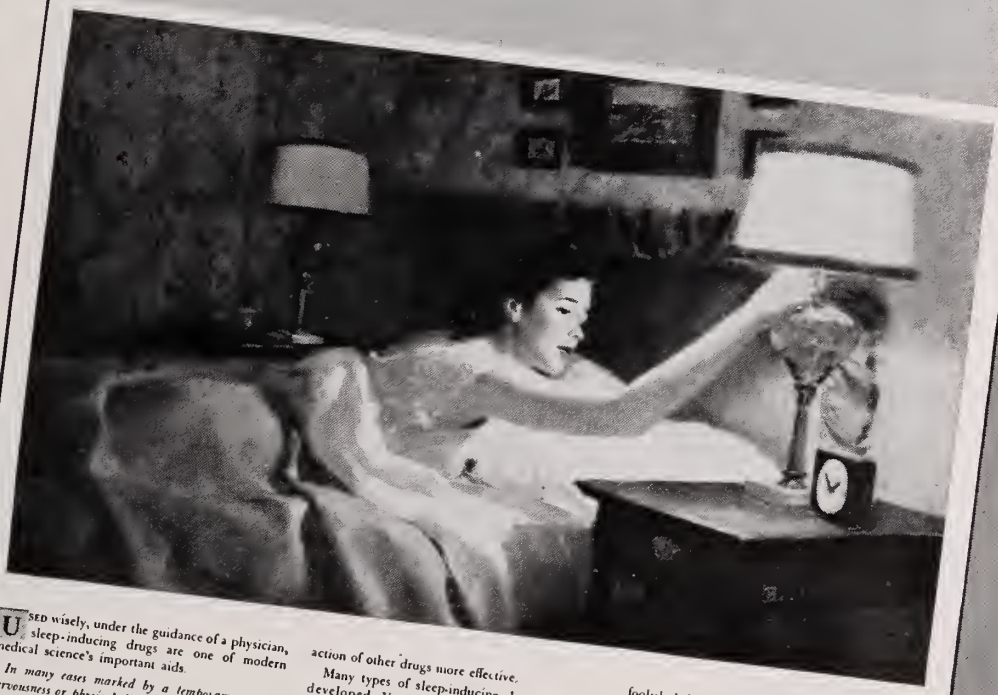
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*Feinberg, S. M.: J.A.M.A., 132: 702 (Nov. 23) 1946.

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Vol. XXX, No. 10 October, 1947

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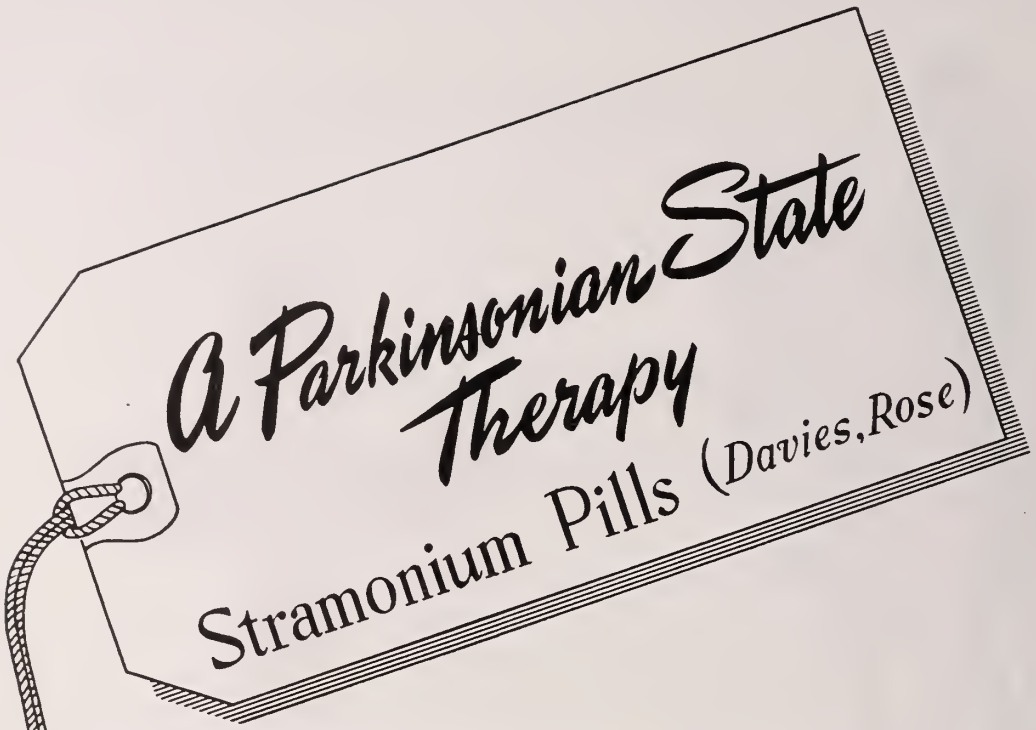
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*Vital Statistics—Special Reports: Vol. 25, No. 12, National Office of Vital Statistics, Washington, D. C. (Oct. 15) 1946, p. 206.

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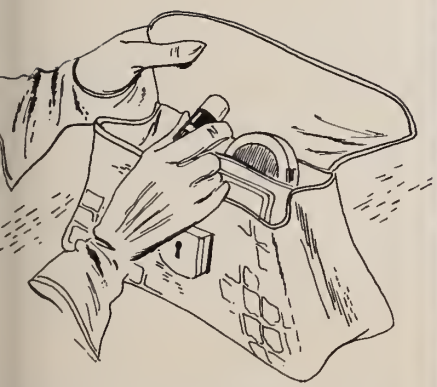
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ABDOMINAL HYSTERECTOMIES PERFORMED AT RHODE ISLAND HOSPITAL, 1941 THROUGH 1945*

Lt. (jg) Robert E. Martin, mc, usnr

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The gynecological literature contains many reports of the surgical mortality and morbidity following hysterectomy. By means of such statistics, some of these reports have endeavored to point out the superiority of either total or subtotal hysterectomy. This study, however, was undertaken to determine the mortality and morbidity following abdominal hysterectomy at the Rhode Island Hospital so that our results could be compared with those from other published reports.

This review includes all the abdominal hysterectomies performed at the Rhode Island Hospital between January 1, 1941, and December 31, 1945. The operations were performed by a large number of surgeons, both general and gynecological. With such a large number of surgeons involved, there were certainly nearly as many different techniques. Thus, there was no standardization of operative technique nor was there any standardization of indications for operation.

A total of 664 abdominal hysterectomies was performed—352 supravaginal and 312 complete. It was only in 1945 that the number of complete hysterectomies surpassed the number of supravaginal.

Chart I presents a resumé of the distribution of the operations throughout the years covered by the study.

Of the 664 patients, 20.5% had had some previous pelvic operation, including appendiceal abscess, peritonitis and D & C with insertion of radium.

CHART I
ABDOMINAL HYSTERECTOMIES
from 1941-1945

Year	*Complete*	*Supravaginal*	*Total*
1941	49	52	101
1942	58	92	150
1943	43	75	118
1944	61	84	145
1945	101	49	150
Total	312	352	664
Mortality	1 (0.3%)	3 (0.9%)	4 (0.6%)

At operation part or all of the adnexae were removed in 83.4% of the cases, while in the remaining 16.6% of the cases hysterectomy alone or hysterectomy and appendectomy was performed. Thirty-three plastic operations were performed at the time of hysterectomy and 19 miscellaneous procedures, which varied from simple umbilical hernia repair to extensive bowel resection.

The patients spent an average of 14.1 postoperative days in the hospital.

Symptoms

No systematic or thorough study of symptomatology was made. However, as far as possible, the chief complaint was recorded. In many instances where there was more than one complaint, the one which had presumably caused the patient to seek medical advice was recorded. Under the complaint "vaginal bleeding" have been included irregular menstrual periods, menorrhagia, metrorrhagia and spotting — in short, any variation from normal bleeding. Forty-nine per cent of the patients presented the complaint "vaginal bleeding". Abdominal pain was present in 23% and knowledge of a

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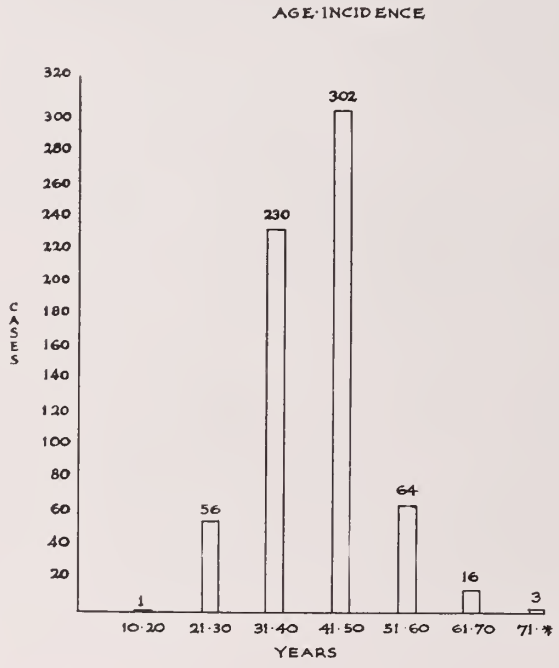
This study was made possible by the guidance of George W. Waterman, M.D., Chief, Department of Gynecology, Rhode Island Hospital.

pelvic tumor in 7.5%. Backache, dysmenorrhea, urinary complaints were each present in less than 5%.

Age

The ages of the patients ranged from 17 to 72, with the greatest majority between the ages of 31 and 50. Chart II shows the age incidence. Forty-five per cent of the patients were in the age group 41 to 50. The next largest age group was that from 31 to 40, containing 34.3% of the patients.

CHART II



The prevalence of hysterectomy in these two age groups corresponds to the predominance of myomata uteri as the most frequent pathological entity found. In the 21 to 30 age group and in the early 30's, residues of pelvic inflammatory disease was the predominating pathologic condition.

A summary of the pathological conditions found is presented in Chart III. In most of the cases more than one condition was present. The two conditions most frequently found together were myomata uteri and chronic cervicitis.

Malignancy of the pelvic organs was found in 39 cases, or 6.0%. Carcinoma of the endometrium was the largest single group, comprising 31 cases. There was one sarcoma of the uterus. One case of carcinoma of the ovary was due to extension from carcinoma of the uterus. The one case of carcinoma of the tube was also due to extension from uterine carcinoma. There were no cases of chorio-epithelioma or hydatidiform mole.

CHART III

PATHOLOGY PRESENT

	Number	*Per cent*
Myomata	373	55.2
Chronic cervicitis	237	35.3
Chronic salpingitis and or oophoritis	160	23.8
Adenomyosis	53	7.9
Endometriosis	46	6.8
Chronic endometritis	21	3.1
Endometrial polyp	70	10.2
Dysplasia of endometrium	46	6.8
No significant pathology	31	4.6
Products of gestation	20	3.0
Ectopic pregnancy	3	0.5
CARCINOMA		
Endometrium	31	4.6
Cervix	3	0.5
Tube	1	
Ovary	3	0.5
Serous cystadenoma of ovary	9	1.3
Pseudomucinous cystadenoma of ovary	6	0.9
Cervical polyp	19	2.8
Myoma & Adenomyosis	23	3.4
Dermoid cyst of ovary	4	0.6
Fibroma of ovary	4	0.6
Chronic appendicitis	206	30.6

Of the non-malignant conditions, myomata uteri was the most frequent, occurring in 55.2% of the cases. Next in order of frequency were chronic inflammatory changes, cervicitis, salpingitis and oophoritis. Chronic appendicitis was encountered frequently because of the almost routine performance of appendectomy.

Endometriosis occurred in 6.8% of the cases. Other observers have encountered up to 20% incidence of endometriosis. Here, however, only the pathological reports are considered. There were numerous cases where the operator described typical endometriotic lesions, but no pathologic report was made.

Adenomyosis was encountered in 7.9% of the cases; and in 43.5% of these, myomata were also found. Of the 53 cases of adenomyosis, 19% were accompanied by endometriosis.

Endometrial polyps were found in 70 cases, for an incidence of 10.2%. This finding is of interest because in a fair number of these cases endometrial polyps were the only demonstrable cause of vaginal bleeding. (Incidentally, curettage before operation was more common in the earlier years of this study than it was in the later years.) The condition most commonly associated with endometrial polyps was either chronic endometritis or salpingitis.

The term "no significant pathology" is used to designate no pathology, secretory endometrium, proliferative endometrium, corpus luteum, Graafian follicle or simple cysts of the ovary.

Morbidity

It is impossible to accurately compare morbidity figures with other reports because of the lack of a morbidity standard. Many standards have been devised, but none in use are wholly acceptable, for each has its obvious flaws. The most commonly used, however, are variations of the obstetrical morbidity standard of a temperature of 100.4° on any two days post partum. Some have adopted this directly substituting postoperative for post partum. The American College of Surgeons have used this, except that they exclude the day of operation. In this study a modification of this standard has been made. Our standard is a temperature of 100.4° on any two days postoperative excluding the day of operation and the first postoperative day. Using this standard we had a gross morbidity of 32.6%, in the complete hysterectomy group 35.0% and in the supravaginal group 30.0%.

Following the example of Jones and Doyle, we have regrouped the cases so that they fall roughly into seven large pathological groups, and we have tried to correlate the morbidity with the pathological group.

The seven groups are: (1) Tumors. These are benign neoplasms of the uterus or adnexae, not complicated by any other condition, such as residues of previous pelvic inflammatory disease, endometriosis or previous pelvic surgery. (2) Residues of previous pelvic inflammatory disease. This group includes all patients who had residues of previous pelvic inflammation, etiology not considered. All adhesions not explained on previous pelvic surgery or endometriosis were classed as residues. (3) Previous operations. This group includes associated pathology usually — adhesions from previous operations, but the patients did not have residues of previous pelvic inflammatory disease or endometriosis. The usual picture was myomata plus adhesions with a history of previous pelvic surgery. (4) Endometriosis. Included are all patients who had any endometriosis or adenomyosis without malignancy. A patient having a benign tumor and endometriosis was classed as endometriosis. (5) Malignancy. Any genital malignancy. (6) Insignificant pathology. Included in this group are functional bleeding, endocrine dyscrasia, dysplasia, proliferative or secretory endometrium without other pathology. (7) Chronic cervicitis and miscellaneous. In this study this group contained cases where chronic cervicitis was the main pathological diagnosis or was present, plus such conditions as retained placental tissue or endometrial polyps.

CHART IV

RELATION OF PATHOLOGY TO MORBIDITY

	Number	*Number Morbid*	*Per Cent Morbid*
Tumors	277	69	24.9
Residues	114	42	36.8
Previous operations	52	17	32.7
Endometriosis	77	29	37.7
Malignancy	39	10	25.6
No Significant Pathology	46	12	26.1
Cervicitis and Miscellaneous	65	33	50.7

Chart IV shows the relation between morbidity and the pathological groups. Because of the indefinite bounds of these groups only a general idea of correlation can be obtained. However, two points are evident; one is the relatively low morbidity in the benign and malignant tumors of the uterus and adnexae, and the second is the high morbidity in the chronic cervicitis and miscella-

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CHART V

CAUSES OF MORBIDITY

ETIOLOGY	SUPRAVAGINAL		COMPLETE		TOTAL	
	Number	*Per Cent*	*Number*	*Per Cent*	*Number*	*Per Cent*
Hemorrhage	2	1.9	1	0.9	3	1.4
Urinary Infection	13	12.2	11	10.0	24	11.2
Thrombophlebitis	3	2.8	5	4.4	8	3.7
Wound Infection	10	9.4	17	15.6	27	12.6
Pelvic Infection	10	9.4	10	9.2	20	9.3
Pulmonary Emboli	2	1.9	0		2	0.91
U. R. I.	3	2.8	2	1.8	5	2.3
Unknown	63	59.2	57	52.0	120	55.9
Pneumonia	0		4	3.5	4	1.8
Distention or Obstruction	4	3.6	1	0.97	5	2.3

neous group. In this group were five cases of retained placenta and one of multiple endometrial polyps and chronic cervicitis. The remainder of the 33 morbid cases had only chronic cervicitis.

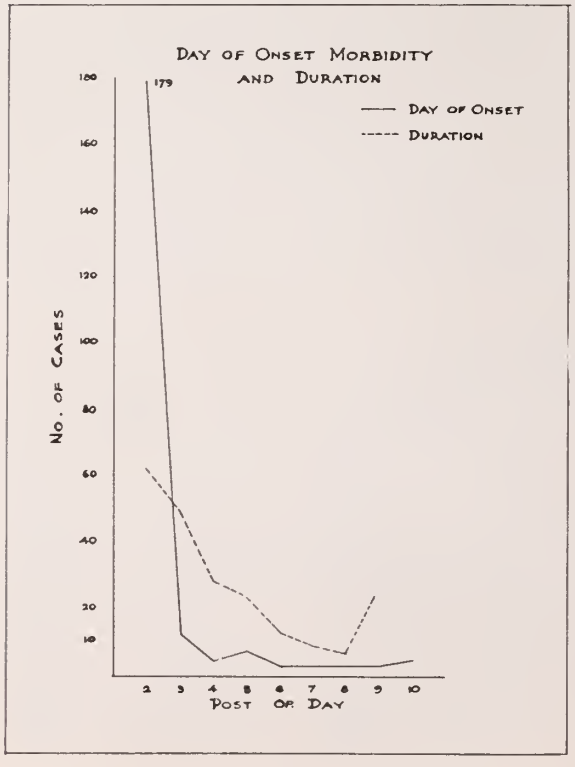
Chart V shows the cause of morbidity. The largest number was in the "unknown" group. Here either no cause of morbidity could be found or none was investigated. This group comprised 59.2% of the supravaginal group and 52.0% of the complete hysterectomy group.

In the supravaginal group, aside from the "unknown", urinary infections were responsible for the largest single number of known cases, 13 (12.2%). Following this were wound infection and pelvic infection each 9.4%. There were two pulmonary emboli in the supravaginal group, neither was fatal. Thrombophlebitis was present in only three cases.

In the complete hysterectomy group there were 17 wound infections accounting for 15.6% of the cases, no proven pulmonary emboli, and four cases of postoperative pneumonia. There was no increase in urinary infection.

Chart VI shows graphically two things. The solid line represents the number of cases that became morbid on a given postoperative day. The striking fact about this graph is that 179 cases or 82% of the patients that were morbid had their onset on the second postoperative day. (The second day is the first one counted for morbidity in this study). There is then a precipitous drop to 12 cases or 5.5% on the third day. The slight rise on the tenth day is due to the fact that all those becoming morbid on or after the tenth day are considered together.

CHART VI



The interrupted line represents the number of days a patient was morbid. Thus, 28.8% were morbid for two days, 22.9% for three days and so on. The slight rise on the ninth day is due to the grouping of all those morbid for more than eight days.

MORTALITY

In the entire series of 664 cases there was a mortality of 0.6% (4 deaths). Three were in the supravaginal group, an incidence of 0.95%, and one in the complete group, an incidence of 0.32%.

The causes of death were: Two myocardial infarctions, one postoperative hemorrhage, and one peripheral vascular disease.

CASE I — 42 YEARS.

Indications for operation: Bleeding myomata.

Preoperative complications: Hypertension and myocarditis. She was considered a poor risk.

Operation: Supravaginal hysterectomy, salpingo-oophorectomy and appendectomy.

Course: The patient died on the fourth postoperative day of a myocardial infarction.

CASE II — AGE 48 YEARS.

Indications for operation: Myomata.

Preoperative complications: Diabetes and Raynaud's disease of a severe nature.

Operation: Supravaginal hysterectomy and bilateral salpingo-oophorectomy.

Course: On the fourth postoperative day the patient's body became cold and clammy. The left upper extremity turned dark purple and was pulseless. The patient went into shock and died. Cause of death was recorded as Raynaud's disease, vascular collapse and diabetes mellitus.

CASE III — AGE 29 YEARS.

Indications for operation: Myoma.

Preoperative complications: None. Patient was in excellent health.

Operation: Supravaginal hysterectomy, right salpingo-oophorectomy.

Course: On the first postoperative day the patient went into shock. She was explored on the second postoperative day and no bleeders were found. There was, however, oozing from the cervical stump. The patient improved briefly after this procedure. However, she went into shock again and died. Cause of death was hemorrhagic peritonitis.

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CORONARY THROMBOSIS AND DIET

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The Author. *Frederic J. Burns, M.D., of Providence. Visiting Physician, St. Joseph's Hospital.*

THIS PAPER is being submitted as a primary one concerning the relation of blood cholesterol with coronory thrombosis.

For many years the association between the two has been well recognized and frequent observations of elevated blood cholesterol have been noted following coronary thrombosis. An evaluation of some of the observations seems to form a pattern that warrants further investigation.

Davis, Stern and Lesnick have reported a tendency to increased cholesterol levels in angina pectoris and in arteriosclerosis, findings with which my own investigation coincides. Dock compared the greater frequency of coronary thrombosis in the members of the American armed forces as compared with the English forces. He further compared the diets of the two forces and readily demonstrated the much higher cholesterol content in the diets of the American army. Well known to all is the relative frequency of the occurrence of coronary artery disease in diabetes and in hypothyroidism, both of which reveal elevated cholesterols. White believes that atheromata, through narrowing of the lumen or ulceration of the intima at the site, may be the cause of the thrombosis. From clinical experience, I believe it has always been a point of conjecture why an emotionally calm individual, who has shown no evidence of cardiovascular disease, is suddenly stricken with coronary thrombosis. Usually no explanation is available and in these particular types of cases surely nervous strain and hypertension can be discounted as the causes.

While the elevation of blood cholesterol does not appear in all cases of coronary artery disease it does appear frequently enough to raise the question, is cholesterol a factor in the disease. Various theories as to the cause of the elevation have been submitted, but none accepted by all.

If a metabolic impairment or an excretory handicap, or both, exist, and whether these are primary in the individual body as, i.e. a hereditary factor, or secondary to another process such as glandular disturbance it seems feasible that attempts should be made to correct the cholesterol level. Particularly does this seem true in view of White describing his finding coronary atheromata in the endarterium. Included here is a microscopic picture of a coronary whose lumen is practically occluded. The distortion is readily seen to be caused by the atheroma in which the vacuoles that held the cholesterol crystals are readily seen. This particular patient did not die of heart disease but it appears apparent that cardiac involvement would soon have made itself felt in view of such narrowing of the lumen.



FIGURE I
Coronary artery atheroma (low power field)

The changing of blood cholesterol level is usually a slow process. Employing a diet presented by Dock, I chose four cases who have had coronary thrombosis. These cases were chosen in view of their intelligent cooperation and in view that they presented no other condition that would per se

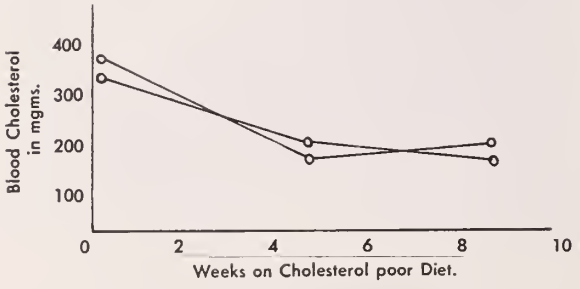
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FIGURE II
High power field view of body of atheroma in Figure I

elevate the blood cholesterol. Two presented fasting bloods that showed normal levels. The second pair revealed definite elevations of 385 mg. and 345 mg. of cholesterol. As seen in the simple chart, both readily lowered their blood cholesterol by following their diet closely. At the end of five weeks, both were within normal range. A recheck four weeks later revealed normal findings in each case. Both patients find the diet not too restrictive. (Chart I)

CHART I



Considering the above it seems logical to me that there exists in many cases of coronary artery disease, either a state of faulty metabolism or excretion that may have a primary origin. In view of the location of the atheromata, the frequency of thrombosis in conditions that per se result in elevated cholesterol, and in view of these cases, granted too small in number to use as a criterion, that lowered their blood cholesterol by dieting, it seems as though such dieting would be of preventitive and corrective value. Realizing that wide investigation must be employed before accepting this as a fact, it seems reasonable that all patients with coronary artery disease should be investigated for cholesterol levels and attempts made to correct the abnormal ones.

ABDOMINAL HYSTERECTOMIES

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CASE IV — AGE 55 YEARS.

Indications for operation: Carcinoma of endometrium.

Preoperative complications: Hypertension and myocarditis.

Operation: Complete hysterectomy, bilateral salpingo-oophorectomy, repair of an umbilical hernia and cholecystectomy.

Course: Patient did well for 20 postoperative days. On the first day up out of bed she had a sudden precordial pain, went into shock and died. Cause of death was myocardial infarction.

Summary

We have attempted to present objectively the surgical morbidity and mortality following abdominal hysterectomy at the Rhode Island Hospital, and to add this report to the literature on this subject.

1. An analysis of 664 abdominal hysterectomies performed between January 1, 1941, and December 31, 1945, have been presented.

2. There were 312 complete and 352 supravaginal hysterectomies.

3. There were four deaths for a gross mortality rate of 0.6%; 0.95% supravaginal hysterectomy and 0.32% for complete hysterectomy.

4. Morbidity statistics have been presented and reviewed.

5. There was little difference in morbidity between the complete and supravaginal hysterectomy groups.

6. Uncomplicated benign tumors and malignant tumors of uterus and adnexae were associated with the lowest morbidity.

7. The pathological group "cervicitis and miscellaneous" was associated with a much higher morbidity than any other group.

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USE OF CHOLINE CHLORIDE IN CIRRHOSIS OF THE LIVER, WITH RECOVERY AFTER 106 PARACENTESES.

LOUIS E. BURNS, M.D.

The Author. *Louis E. Burns, M.D., of Newport, R. I. Senior Staff Physician, Newport Hospital.*

THE PATIENT, Mrs. M. S., is white, married, 45 years old. Her health had been good, except for a left oophorectomy due to an ovarian cyst, and an appendectomy. There was normal birth of one child.

When I first saw her at the age of 40 in June of 1942, she had been drinking heavily for eight years — mostly hard liquor. She had previously enjoyed a good appetite and had been eating a well balanced diet. As her drinking progressed, particularly for the last few years, her appetite began to wane, and she confined her eating largely to soup and some white bread and pastry. She drank no milk, ate no cereals, very little meat, and then began to skip meals altogether — often had only one poor meal a day. She started early and drank just enough to keep a steady glow all day. Patient does not know why she drank, and now wonders how she lived at all on the small amount of food she ate. For some time she realized that she had not been feeling up to par, but could not get up courage to go to a doctor or give up her drinking. Finally she became so ill, medical aid was sought.

When she was first admitted to the Newport Hospital, Newport, Rhode Island, June 10, 1942, she was extremely weak, constantly tired, constipated, had developed a mild jaundice, itching of the skin (see icteric index Laboratory Sheet), indigestion, gas and nausea. On admission to the hospital, the use of intoxicants was stopped, and she has not had a drink since.

The physical examination was essentially negative, except for red, shiny tongue and cheilitis. There was an icteric tinge to the sclera, the abdomen was slightly distended and the liver palpable to four fingers below the costal margin. Pulse was 100, with daily elevation of temperature to between 100 and 101 every afternoon at four o'clock.

Treatment on the first admission was Vitamin B Complex ½ cc. and Liver ½ cc. (Lilly's) — both s.c. daily. Vitamin B Complex capsule one t. i. d. A high protein diet, with the least amount of fat possible, was ordered.

There was a clinical improvement. The jaundice decreased and the bile in the urine decreased from a 2 plus to a plus minus. After 14 days, the patient was discharged in ambulance, June 28, 1942, to continue above therapy at home. The final diagnosis was cirrhosis of the liver and hypovitaminosis.

The patient was admitted to the hospital for the second time on July 30, 1942. The abdomen was markedly distended, very slight icteric tinge to the skin, (see icteric index) tongue still red and cheilitis still present. The high protein diet, with low fat, was continued, with fruit juices ad lib. Vitamin B. Complex 1 cc. daily, Nicatinamide 100 mgs. t. i. d., Riboflavin 5 mgs. t. i. d. was given. (See Laboratory Sheet for red count, icteric index, low urea nitrogen, and low total protein with inverted A. G. ratio.

The first abdominal paracentesis was done August 6, 1942, in midline midway between umbilicus and symphasis with patient in sitting position, and 9000 cc. of slightly turbid fluid (2¼ gal.) was removed. She was tapped again on August 15, 1942, and 5½ quarts of yellowish fluid was obtained. On August 17, 1942, she was discharged to her home in ambulance to continue the above treatment.

Patient was admitted to the hospital for the third time for paracentesis only on August 25, 1942. The condition of the tongue and lips was the same, and the liver now extended down to the level of the umbilicus. Patient's abdomen was hard and distended, and she complained of severe pain in the lower back. Blood pressure was between 100 and 110. Medication was the same as on the previous admission. A paracentesis done August 26th obtained two gallons of dark amber fluid. She was discharged to home in ambulance to continue with the above treatments.

The first paracentesis was done August 6, 1942, and the last paracentesis on September 2, 1944. During this period 106 paracenteses were performed, an average of about six quarts of fluid being obtained each time. (Approximately 159 gallons in all.) The paracenteses done at home were performed with nursing nuns, the Sisters of the Holy Ghost (White Sisters) in attendance. These nuns also administered the daily therapy.

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DISCUSSION AND TREATMENT. In order to replace the protein lost with each paracentesis, it was necessary to supply a tremendous daily intake of protein. If our thinking was correct, we had to have a high protein, high carbohydrate and low fat diet. If we depended on meat alone, the fat intake would have been too high, so we decided upon cottage cheese to keep the fat relatively low and supply a high protein intake. The patient ate a quarter of a pound of cottage cheese at least five times weekly, which she varied by adding jams and jellies. She drank at least a quart of skim milk a day, ate at least a half a pound of meat a day and more if she could get it. She was also given aminoids daily. All this food was divided up into three large meals and three small meals daily, and the patient observed "All I do is eat, take medicine, hypodermic injections, get tapped and try to sleep". During meat rationing, extra coupons were granted. We tried to keep the fat intake low.

By the addition of cottage cheese and skim milk to make up the protein, from the casein of cottage cheese we were adding the necessary methionine so essential in preventing deposition of fat in the liver and hemorrhagic degeneration of other organs,[1] shown experimentally by Griffith and Wade. This diet was adhered to for well over three years, when it was gradually modified to more nearly a normal diet, but still adhering to the high protein and moderate fat, with cottage cheese two to three times a week.

Liver injections unconcentrated (Lilly's) 1 cc. were given daily, also Vitamin B Complex (Lederle) 1 cc. daily, Brewers' Yeast Tablets 12 a day. After a visit with Dr. R. O. Muether,[2] in October, 1942, Choline Chloride grains 5 t. i. d. was started, made up with Elixir of Vitamin B Complex giving 5 grains to the dram. Patient got the liver injections and Vitamin B. Complex injections every day for three years, then we used it three times a week, then twice, then once a week and finally discontinued it in January, 1947. The Choline has been continued to date, although we have switched to the Choline Di-Hydrogen Citrate by Lilly. At present the Choline is the only medication given.

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LABORATORY WORK

Newport Hospital, Newport, Rhode Island

	June 10, 1942. First Admission	July 30, 1942. Second Admission	Aug. 25, 1942. Third Admission	June 16, 1947. Fourth Admission
Urine	2 plus bile otherwise negative	1 plus bile otherwise negative	1 plus bile albumen 1 plus	bile absent albumen plus minus otherwise negative
Kahn	Negative	Negative	Negative	Negative
Takata-Ara reaction	Negative			4 plus positive
Hemoglobin	80	82	80	89
Red blood count	3,580,000	3,930,000	4,030,000	4,240,000
Color index	1 plus		1 minus	1 plus
White blood count	7,100	5,900	8,500	3,700
Neutrophiles	72%	68%	71%	71%
Lymphocytes	28%	32%	29%	28%
Eosinophiles				1%
Icteric index	50	25		7
Coagulation time	4 min.			
Bleeding time	¾ min.			
Urea Nitrogen		7.5		
Total Protein		5.8		6.48
Albumen		2.6		4.31
Globulin		3		2.17
Sedimentation rate	28 mm in 60 min. There was a rapid even fall to 25 mm the first 45 min.			
A. G. Ratio		.9		1.9

CLINICOPATHOLOGICAL CONFERENCE

Rhode Island Hospital

Discussion by CHESTER S. KEEFER, M.D. of Boston, and B. EARL CLARKE, M.D.
Pathologist, Rhode Island Hospital, Providence

NAME: R. T.
AGE: 31
ADMITTED: November 20, 1946

A 31-year-old white Jewish housewife was admitted to the hospital because of high fever and drowsiness.

The patient had apparently been well until three days before admission, at which time, she developed a fever. Her family physician prescribed ten white tablets which were presumably one of the sulfonamides. The following day her throat became sore. On the day of admission her temperature had become further elevated and she was lethargic. She had vomited a number of times. She denied having any cough, sputum, muscular pains or other complaints. There had been no known exposure to any communicable disease nor had there been a skin rash.

PAST HISTORY:

No serious illnesses.

FAMILY HISTORY:

No familial disease tendencies and no known exposure to tuberculosis.

PHYSICAL EXAMINATION:

Temperature 105.4 rectally; Pulse 130; Respirations 28; Blood pressure 115/65.

The patient was a normally developed, well-nourished, lethargic, acutely ill female. Her eyes were grossly normal with pupils that were equal and reacted to light. The fundi were normal. The pharynx was injected and two pustules were present on the hard palate. The neck was supple and there was no adenopathy or tracheal deviation. Her chest was resonant without rales and the breath sounds were vesicular. The heart was not enlarged and the rate and rhythm were normal. No murmurs were heard. The abdomen was soft, flat and no masses or organs could be palpated. The neurological examination revealed no pathological reflexes or paralyses.

An X-ray of the chest taken on admission revealed some slight haziness visible on the lower half of the left chest and obscuring the diaphragm. The cardiovascular outlines were normal. WBC 4,350 with 46% polys; 37% polysm; 17% metamyelocytes and 0% eosin. A blood culture taken on admission was sterile.

COURSE:

The following morning (11-21-46) patient was semicomatose with no deep reflexes demonstrable in her arms or legs. Her neck was somewhat resistant to flexion and there were suspicious reactions to the Kernig test on the right and to the Babinski test on left, but these were not considered positive. There was no clonus or paralyses. The abdominal, patellar and Achilles reflexes could not be elicited. There were two areas of ecchymoses in the right axilla and right upper arm.

A lumbar puncture revealed an initial pressure of 210mm, normal dynamics and final pressure of 80mm after 15cc of crystal, clear fluid had been removed. This fluid contained polys 0; lymphs 2; RBC 4; gave a negative Hinton reaction and a goldsol of 1111000000. The fluid was sterile with 18 mgm of protein, negative globulin and 120mgm of glucose. A throat culture was negative for hemolytic streptococci. A blood culture was sterile. WBC 5,850 with 74% polys; 23% lymphs; 3% monos; 0% eosin. Hemoglobin was 12.0. RBC 4.15. The results of agglutination studies were typhoid H positive 1:40; typhoid 0 positive 1:160; undulant fever negative. BUN 18; blood glucose 168. The blood Hinton test was negative and two blood cultures were sterile. Urine: Protein 2+; sugar 3+; acetone 0; RBC 0-1; WBC 1-2; casts 1-2 fine granular. A urine culture was sterile. The patient developed difficulty in swallowing and would bite anything placed in her mouth.

11-22-46—The third hospital day a neurological examination revealed no pathological reflexes. The optic discs were normal. The right triceps reflex was 2+, the left 1+. A stool culture was negative for dysentery, typhoid, pyocyaneus and paracolon groups.

11-23-46—A transfusion of 500cc of blood was given. A second lumbar puncture revealed an initial pressure of 190mm and a final pressure of 170mm after 6cc of clear colorless fluid was removed. The cell count of this fluid was 132 RBC, one lymph and it was sterile.

continued on next page

The patient's color was good. Respirations were noisy and there was considerable mucus in pharynx. A pelvic examination revealed no abnormalities except that she was passing some blood from her uterus. The catheterized urine was amber with specific gravity of 1.011; pH5; 2-4 RBC; 9-5 WBC; 2-11 coarse granular casts.

11-24-46—The blood smear showed 38% polymorphonuclear neutrophils; 30% metamyelocytes; 7% small lymphocytes; 22% large lymphocytes and 3% monocytes. The platelets were reduced and the red blood cells were normal. A transfusion of 500cc of blood was given.

11-25-46—There was a slight papular erythema over the malar regions, across the nose and on the chin. A transfusion of 500cc of blood was given.

The patient was given penicillin 50,000 units on admission and 40,000 units every three hours throughout her illness. Beginning on the fourth hospital day (11-23-46), in addition to the penicillin, 250mgm of streptomycin was given every three hours. She continued to be semicomatose throughout her illness. During the last two days she developed difficulty in breathing and was intermittently cyanotic. She continued to bleed from her vagina and there was bleeding from her mouth and nose. She passed a number of loose or soft brown stools incontinently during the period of her hospitalization.

Her temperature became lower by lysis to 102 rectally on the 4th hospital day and then dropped suddenly to 97 rectally. It remained slightly irregular between 98(r) and 101(r), until she expired on her 7th hospital day (11-26-46).

Discussion by Chester S. Keefer, M.D. of Robert Dawson Evans Memorial Hospital, Boston

The central problem in this case is the explanation of the rapidly progressive fatal illness in a young woman of 31 years of age who was apparently well until 10 days before her death.

Let us review together some of the salient features of the history.

This patient was in good health until 3 days before admission, when there was a sudden departure from health with the symptoms of an acute infection and sore throat. She received some medication without relief and was admitted to hospital. There was nothing in either the past or family history to contribute to the present illness.

The examination showed the following: There was high fever, tachycardia, slightly elevated respiratory rate and a normal blood pressure. There was no evidence from examination that the patient had had any chronic illness preceding the acute episode since she was well nourished and normally developed. She was lethargic and acutely ill, but there were no localizing signs of disease on physical examination to enable one to make a specific clinical diagnosis.

The X-ray of the chest disclosed some visible haziness over the lower half of the left chest obscuring the diaphragm. There was a leukopenia with 17 per cent metamyelocytes and a sterile blood culture.

The course of her illness may be summarized as follows. Soon after admission to hospital, she became semicomatose, and the deep reflexes were absent, and two areas of ecchymoses were noted, one in the right axilla and the other over right upper arm. A lumbar puncture showed a moderately increased pressure, but the spinal fluid was normal. On this day, we are told that the white blood count was normal, along with the differential count. There was a slight anemia. The other examinations were essentially negative. She then developed difficulty in swallowing. There was no further change in the neurological examination on the third day. On the fourth day a blood transfusion was given. A second lumbar puncture was done and the pressure was slightly elevated and was reduced only slightly following the removal of 6 cc. of fluid containing 132 red blood cells and one lymphocyte. The increased RBC may have been traumatic. It was then noted that she was passing blood from the vagina. The following day, 30 per cent metamyelocytes were noted and the platelets were reduced. A transfusion of 500 cc. of blood was given on two successive days. Penicillin and streptomycin failed to change the course of the illness. She continued to be semicomatose, developed difficulty in breathing, and had bleeding from the mouth and nose as well as the vagina. The temperature was irregular during the period of hospitalization.

The diagnosis then must account for the acute onset with sore throat, high fever, bleeding into the skin and from the mouth and nose and vagina, the low platelets, the metamyelocytes, the stuporous state.

The first diagnosis I want to mention is an acute leukemia. The blood smear was not characteristic of leukemia in all respects, since there was no anemia, although this feature might have been masked by the blood transfusions and the acuteness of the process. The low platelets were consistent with the diagnosis as were the hemorrhagic phenomena, the sore throat and the high fever. The semicoma and other neurologic lesions may be accounted for by the associated intoxication or by hemorrhages into the brain.

The second possibility might be a purpura hemorrhagica secondary to some infection or of some unknown cause. The hemorrhages, and the low

platelets are consistent with such thoughts, but in general, patients with purpura hemorrhagica have bleeding at the outset and many petechial hemorrhages as well as ecchymoses; while fever may be a feature, it is infrequent in my own experience to see purpura hemorrhagica begin in this way, and run this course.

I return, then, to acute leukemia, as the most likely diagnosis in spite of the lack of certain features that might well clinch the diagnosis, such as a typical leukemic blood picture.

Let us review some of the salient features of acute leukemia. The diagnosis of this disease is usually based upon three main points: 1) the clinical features; 2) the blood picture; and 3) the course of the disease. It is confirmed at necropsy by finding leukemic changes in the bone marrow and other tissues.

First of all, I shall say something about the clinical features. It is a disease that tends to produce symptoms abruptly. It is seen most often in childhood and adolescence, and early adult life although it is occasionally seen in the elderly or aged. The sex distribution is about 2 males to 1 female. There are two common features that call the patient's attention to the disturbance: 1) a febrile illness with a sore throat or ulcerative stomatitis; 2) excessive bleeding following a tonsillectomy or tooth extraction. Bleeding may occur from other organs, such as the nose, vagina, or gastro-intestinal tract. Less often the disease announces itself with a rapidly progressive anemia, or a febrile illness with nausea, vomiting, abdominal distention, diarrhea and bloody stools, or in rare cases by neurological symptoms such as a bilateral facial palsy or a cerebral hemorrhage.

The blood picture usually clinches the diagnosis. The characteristic features are 1) a rapidly progressing anemia, 2) an increased leukocyte count with a differential formula showing a predominant number of immature cells, 3) a decrease in the platelets. Early in the course of the disease the red blood count and hemoglobin may not be greatly depressed. The leukocyte count may not be over 10,000 in more than half the cases, and in 3 to 5 per cent no myelocytes are found in the peripheral blood. The clinical course of the disease is one of rapid deterioration with death following in most cases in a period under 4 to 8 weeks. In the cases reported by Warren, death occurred within 2 weeks of the onset in 18 per cent of the cases. No treatment is effective. Multiple blood transfusions or radioactive phosphorus may be palliative but the end is always the same. *This is a dramatic disease.* It is a disease that often makes the newspapers, and creates great anxiety and distress.

The features of this patient's illness that suggest leukemia were the acute onset of a febrile disorder with a sore throat, the rapid deterioration with semicoma and stupor, the bleeding from the nose, mouth and vagina, the bleeding into the skin. The blood picture was not wholly characteristic in that the anemia was only moderate and there were only a few atypical and early myelocytes in the peripheral blood, although the platelets were reduced.

The clinical features and course of the disease were consistent with the diagnosis of acute leukemia, but the blood picture was not absolutely characteristic in all respects. The sum of the evidence then suggests to me that the most likely diagnosis was acute myelogenous leukemia.

My final diagnosis will read:

Acute myelogenous leukemia
Symptomatic P. H.

Discussion by B. Earl Clarke, M.D., *Pathologist,* R. I. Hospital, Providence

The significant postmortem findings are in the kidneys and the heart. The kidneys exhibit typical features of a lesion which has recently been designated by Luckè as lower nephrom nephrosis. There is in addition a peculiar interstitial myocarditis and some arteritis of myocardial vessels (demonstrates gross and microscopic findings).

Lower nephron nephrosis is associated with a number of conditions including shock caused by various types of injury, blood transfusion reactions, and sulfonamide intoxication. This patient had blood transfusions but there is no reason to suspect a reaction. In any case I do not know of such cardiac lesion being found in cases dying of transfusion reaction. Sulfonamide intoxication on the other hand does result in both types of lesion. I suggest that the "pills" given before admission were sulfonamide and that the patient died as a result of sulfonamide hypersensitivity. Bone marrow and other organs exhibit no evidence of leukemia.

ABDOMINAL HYSTERECTOMIES

concluded from page 728

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PARTICIPATION IN THE SURGICAL INSURANCE PROGRAM

THE RHODE ISLAND MEDICAL SOCIETY, by action of the House of Delegates, has adopted a voluntary prepaid surgical and obstetrical insurance program. The plan is not fool-proof. It may reveal some flaws as its administration is started; but it is as sound and practical as advance study can make it.

The program won't work — unless the medical profession of Rhode Island actively participates.

Participation means several things. Foremost, it means signing the agreement with the Society to accept the charges for services included in the master schedule of surgical indemnities as the complete fee for persons below a set income limit. This action does not restrict any physician in the exercise of his right to refuse to treat any patient for appropriate professional reasons. It does mean the physician will abide by the rulings of the society's Health Insurance committee which will include a representative of each of the district medical societies.

Secondly, participation by the physician means that he will not abuse the indemnity feature of the program as applied to persons in the income groups above the limits set by the Society. The total bill for services to persons liable for any additional fee should be consistent with the usual fee prevailing in the community for that service. To act otherwise will not only jeopardize the surgical plan, but will also prove disasterous from a public relations viewpoint for the entire Profession.

Thirdly, the participating physicians should accept the responsibility of encouraging their patients to purchase insurance contracts. This task does not call for a detailed merchandising job for the busy doctor. It merely requires that he promote the program for the advantage of the patient and himself. If the threat of bureaucratic federal control of medicine is to be dissipated it will only be accomplished by showing that the voluntary method not only can work if given the chance, but actually does.

The stakes are high. The protection of the American standard of living is threatened. Medicine is meeting the first onslaught, and failure to prove its case will pave the way for the downfall of other phases of our democratic system.

That is why we look with optimistic hope to the insurance industry, encompassing the accident, health and life groups, to aid us in making this program a success. American insurance companies have the respect of the public. They form a bulwark against economic disasters far greater than any government agency ever could. Experience

has been gained by the insurance industry in a plan similar in some respects to ours in Wisconsin. That knowledge, plus the broad and comprehensive principles set forth by us, should make the Rhode Island program a pattern for the country at large.

We also look to the own Blue Cross organization, with whom we did not see eye to eye relative to the mechanics proposed for administering a surgical program for us earlier this year, to recognize in our latest proposal an opportunity to expand its community service by participation in merchandising surgical contracts. The success it has attained in the hospitalization insurance field should enable Blue Cross to promote lively competition with other insurance companies to the advantage of the public seeking insurance to meet the cost of surgical care.

Participation by industrial leaders and organized labor groups forms another major movement which we shall seek for the success of our program. Industry has made long strides in recent years in its development of fine in-plant health and safety programs, including not only the removal of employment hazards but also the care of industrial accidents by professional personnel working in well-equipped first aid rooms.

Many employers have of their own accord granted liberal hospital and medical care services as part of an employment contract. Others have taken the action at the insistence of labor groups bargaining for wage contracts, and then have recognized the value and the importance of the benefits to their workers. The Rhode Island Medical Society surgical insurance program should appeal to industry and labor alike.

Employer, employee, insurance company representative, physician—all have vital roles to play in making the new program a success in Rhode Island. But the physician is the most important participant.

GENERAL PRACTITIONER

NEWS ITEM: On Jan. 7 the American Medical Association will give a gold medal to a general practitioner selected from the country at large.
Dear Medical Ass'n.,

I been hoping you'd do something like this for over 35 years, and I'd like it to be our family doctor, who has been doctoring us ever since we thought the first baby was a tumor.

You probably never heard of him. He's not one of your big men—never invented anything in a medical way except a little spool and darning needle gadget for removing ingrowing hairs, and the only time he got into your journal, he says, was the time he had a queer fever of his own. But I feel better the minute he comes into the house, for he doesn't come to see a lot of organs, he comes to see ME. He knows me—knows us all—inside and out, warts, scars, disposition, everything. He knows I can't eat tuna fish, that I get flighty with two degrees of fever, and overdo everything from mowing the lawn to drinking beer. And somehow he manages to add all these things up to make me feel like somebody. I don't believe I'd ever be an "interesting case" to him no matter what I got. I'd just be me. That's really something these days. I don't have to call on him often, but I'd be lost without him.

He's a grand all-round man, good story teller, good listener, good friend, a sort of father confessor with the aid of a stethescope. It's unbelievable the good he's done in our neighborhood. A lot of people owe him money. I'd certainly like to see him get the medal.

Yours sincerely,

Almost Anybody

. . . Editorial Reprinted from the Providence Evening Bulletin, September 19, 1947.

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC., REQUIRED BY THE ACT OF CONGRESS OF AUGUST 24, 1912, AS AMENDED BY THE ACTS OF MARCH 3, 1933, AND JULY 2, 1946

of *Rhode Island Medical Journal*, published monthly at Providence, Rhode Island, for October, 1947.

State of Rhode Island } ss.
County of Providence }

Before me, a Notary Public in and for the State and county aforesaid, personally appeared Peter Pineo Chase, M.D., who, having been duly sworn according to law, deposes and says that he is the Editor-in-Chief of the *Rhode Island Medical Journal* and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily, weekly, semiweekly or triweekly newspaper, the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, as amended by the Acts of March 3, 1933 and July 2, 1946 (section 537, Postal Laws and Regulations), printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are: Publisher, Rhode Island Medical Society, 106 Francis Street, Providence 3, R. I.; Editor, Peter Pineo Chase, M.D., 106 Francis Street, Providence 3, R. I.; Managing Editor, John E. Farrell, 106 Francis Street, Providence 3, R. I.

2. That the owner is Rhode Island Medical Society, 106 Francis Street.

3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are: None.

4. That the two paragraphs next above, giving the names of the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company but also, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest direct or indirect in the said stock, bonds, or other securities than as so stated by him.

PETER PINEO CHASE, M.D., *Editor-in-Chief*

Sworn to and subscribed before me this 18th day of September, 1947.

JOHN E. FARRELL, *Managing Editor*
(My commission expires June 30, 1954

[SEAL.]

THE RHODE ISLAND MEDICAL SOCIETY, through its policy making body, the House of Delegates, has approved of a program for voluntary prepaid non-occupational surgical and obstetrical insurance which it plans to submit to all duly licensed insurance companies and the Blue Cross to increase the extent to which insurance against the cost of surgical care is made available to the people of this State.

The Society, through its various committees, has given the problem intensive study for many months. The report of the surgical study committee as submitted to the House of Delegates represents a new and, we believe, an outstanding approach to the question of providing insurance at the lowest practicable cost to meet surgical expenses.

The fundamental reason for the program is to assist the person with a low or moderate income. Therefore, the Society is asking its members to subscribe to an agreement with it to provide complete surgical service for persons whose annual family income is under certain limits. These are the people for whom we are most concerned in our efforts to alleviate what is spoken of as the costs of catastrophic illness. For persons above the income limit our program, as does the voluntary hospitalization plan for its subscribers, provides an indemnity fee to be applied towards the total cost.

As the Committee has noted in its report the program will have its flaws. Experience, however, will enable us to improve the plan, and the Society is creating a permanent Health Insurance Committee, statewide in its representation, for the purpose of taking appropriate action upon administrative matters and complaints of insured persons or physicians. All policies under our program must be approved by the Rhode Island Medical Society prior to their sale.

The Society will extend all its efforts in the next three months to seek the adoption of this program by all insurance groups and Blue Cross. Our new Health Insurance Committee has been authorized by the House of Delegates to act with authority, and we confidently look forward to the sale of policies approved by the Society by January 1, 1948.

We hope that the program will attain the success it warrants if we are all to support the voluntary process of providing for personal health and welfare. For the Society the program is contemplated as the first step towards what it ultimately anticipates will be a complete medical care program available at the lowest possible cost under the highest standards of medical care in Rhode Island.

ARTHUR H. RUGGLES, M.D.
President,
Rhode Island Medical Society

REPORT OF THE SURGICAL INSURANCE PLAN STUDY COMMITTEE OF THE RHODE ISLAND MEDICAL SOCIETY TO THE HOUSE OF DELEGATES

(As Adopted By the House of Delegates, September 15, 1947)

At the January, 1947, meeting of the House of Delegates of the Rhode Island Medical Society it was voted that a committee of five members be appointed "to study ways and means of putting in effect a Rhode Island Medical Society low-cost prepaid surgical plan as of its own, or through the possibility of having a private insurance company take the plan over."

The Committee was subsequently named by the House of Delegates and it held its organization meeting on February 10 at which time Dr. Rocco Abbate was named chairman.

From the start of its study the Committee has approached its task with a wealth of data accumulated by previous committees of the Society that labored long and zealously on the problem of prepaid surgical insurance. The Committee is indebted to these previous committees for their files of information that aided materially in reaching the conclusions advanced in this report.

The Committee has carefully noted its instructions from the House of Delegates. It has viewed the processes necessary for establishing a program under the Society's own administration and it has viewed the development of such plans as Mutual Medical Insurance, Inc., of Indiana, and Ohio Medical Indemnity, Inc., in which stock or mutual insurance companies were organized by agencies of the medical profession in order to accomplish what was sought under the proposed enabling legislation.

The Committee has been fully cognizant of the difficulties that beset the Society in its previous negotiations aimed towards the development of a program under the supervision of a single insurer. Therefore, the Committee has endeavored to explore the field of private health and accident insurance for a possible new answer to the Rhode Island problem.

According to the Health and Accident Underwriters Conference more than forty million persons were covered under some form of health and accident insurance at the end of 1944, representing a five-fold increase over 1934 when about eight million people were insured. The total has steadily increased in the past two years. The wide actuarial experience that has been gained, plus the competition resulting with the advent of pre-payment medical care plans sponsored or approved by the medical profession, has resulted in new approaches to the extension of this form of coverage by private insurance companies.

Our preliminary proposal to all insurance companies licensed to do business in Rhode Island in which we utilized the indemnity schedule previously accepted by the House of Delegates, and added an agreement including policy provisions, met with an immediate response. The Conference Committee on Health Insurance, organized a year ago by the insurance industry for the purpose of conferring with representatives of the medical profession and hospitals in the development of insurance plans in the health insurance field, asked if it might meet with us. We agreed to hold discussions with this conference committee, and we have found their approach to our problem sympathetic and cooperative. Private insurance has already gained much experience in a plan somewhat similar to ours in the state of Wisconsin; but what we had set forth, and what we have since developed, contemplates far more than has been outlined by any other state medical society.

Your Committee holds the strong belief that if its proposal will be accepted by all the major insurance companies in the health, accident, and life groups, the competitive sale of contracts to provide for the payment for surgical and medical care on a prepaid basis in this state will result in the lowest cost possible on a sound, actuarial basis. We have not looked with favor on several recent plans whereby a single insurance company has been given the approval of a state medical society as the sole merchandising agent for surgical-medical insurance in that state. We believe that only through competition can rates be brought low, and only through the availability of several insurers can there be a guarantee against a monopolistic plan that might remain static.

However, the approach to any program of surgical or medical insurance warrants consideration of many factors. The Committee calls to your attention at this time some phases of this problem in Rhode Island that are generally overlooked, and yet are certainly basic issues that must be recognized and admitted as part of the program.

continued on next page

Difference Between Hospitalization and Surgical Insurance

First we would direct attention to the wide difference between hospitalization insurance and surgical-medical insurance. The success of the Blue Cross hospital program has created a popular impression that a surgical plan can be as simply operated and as successfully promoted. In our opinion this is not true. The hospitals, as community institutions of long standing, are well organized, and are planned to provide a specific service that is primarily institutional. Further, the hospitalization program needs only to contract with a dozen institutions for a limited number of specified services towards which it will pay a cash indemnity for the patient requiring those services.

In the surgical plan, however, the program calls for the services by approximately a thousand individual physicians in their offices, the patients' homes, or in the hospitals, and for several hundred different procedures for which the fee varies according to the type of operation. This plan, then, calls for a far greater problem of administration, and consequently involves an administration cost, under whatever sponsorship, that must affect the premium charged.

The Female Employment Problem

Secondly, and of paramount interest in considering the cost factor in surgical-medical insurance, is the fact that we have the highest female employment of any state in the country. For example, of those engaged in manufacturing 38 per cent of the employment in the major industries in the State is female. According to data accumulated by the Division of Statistics and Census of the State Department of Labor certain industries have as high as 50 per cent women in their employment. Examples: the textile industry as a whole, with approximately 58,000 workers, has 26,700 women employed; the jewelry trades have 50.6 per cent women, showing approximately 6,500 females employed of a total employed group of 13,000; electrical machinery has 42.6 per cent with 2,300 females out of an estimated 5,500; and the rubber industry, 3,320 females out of an estimated 6,500, for a percentage of 50.1.

These figures take on added significance in the consideration of surgical-medical insurance. The higher incidence of illness for females is a matter of record, and therefore, a determining factor in the writing of health insurance under any sponsorship. The medical statistics of the State cash sickness compensation program for the benefit year 1944-1945 offer striking example of the proportionately higher incidence of illness in female employees than males, in spite of the fact that the employed population is prepondantly male. For this benefit year there were 17,029 males of all ages to receive illness benefits, while the number of females, married and single, who were compensated for illness totaled 20,644.

Insurance companies do not gamble. They base their reports and estimates on statistical facts and therefore the female employment situation in Rhode Island, more so than in other states, will affect the group insurance premium. The extent to which it will affect the premium charge for surgical insurance is best illustrated by the rates projected by one outstanding national insurance company as follows:

Where Percentage of Female Employees is—	Premium Charge for Employee alone would be—
Less than 11 per cent	$ .57
11 — 21 per cent	.66
21 — 31 per cent	.71
31 — 41 per cent	.77
41 — 51 per cent	.83

Hence, within the textile industry, for example, the workers in a cotton mill with 50.7 female employment might be subject to a premium charge seventeen cents higher than those in cotton finishing where the female employment is but 17.3 per cent. A favorable aspect in regards to a group contract with private insurance, however, would be the premium refund at the end of the policy year on the basis of a good experience.

Thus, it is apparent that our employment situation presents an insurance cost penalty that is unavoidable. The problem is projected in this report mainly to point out clearly that a comparison of premium rates for similar services in another state cannot be fairly compared with any established in competitive trade here without an understanding of the factors influencing that rate.

Is There a Demand for Surgical Insurance?

Thirdly, the Committee has given consideration to the need for surgical insurance, and more particularly the demand for it. There is no way of estimating at this time the number of surgical procedures performed in the office or the home, provision for which is contemplated under the surgical insurance plans considered by the Society. But a study of hospitalized surgical operations in Rhode Island hospitals for the year 1944 showed a total of 28,151 operations, exclusive of births at Providence Lying-In Hospital. How many of these operations were traceable to occupational illness or disability, and thereby compensible under the workmen's compensation law, how many were done on free service at the hospitals, and how many were veterans is not known to the Committee. But we do feel that the tendency among the general public is to regard the protection against occupational disability as paramount, and since compensa-

tion is provided for such accidents and illnesses there is a reluctance to purchase insurance for non-occupational disability.

We believe, however, that the availability of several low cost contracts to provide surgical coverage for the worker and his dependents for non-occupational illness, properly publicized, and backed by the support of the medical profession, would overcome this reluctance. We believe the people of Rhode Island are both willing and anxious to secure protection against the costs of preserving their good health, and we believe that the people will recognize in competitive private insurance programs an answer to this question far more satisfactory than any compulsory or monopolistic tax-supported plan.

Income Limits

The Council on Medical Service of the American Medical Association in its 1947 report on Voluntary Prepayment Medical Care Plans makes the interesting observation regarding income limits that

> "The use of income limits is an important factor to the public because its intended function is to protect a specified income group from additional charge. However, studies of physicians' charges in relation to patients' incomes actually show that even in cash indemnity plans the income limit theory is closely adhered to by the profession."

In this connection your Committee notes with interest that the surgical insurance plan in Delaware is written as a rider to the hospitalization contract, and there is no income limit. Yet this surgical plan has sold more than 100,000 subscribers and both the public and the profession have been satisfied.

However, we believe that the medical profession would make a tremendous contribution to the progress of social insurance on a voluntary basis if it adopted the proposal that persons whose annual family income is under certain limits shall receive complete surgical service for the indemnity fee listed.

Neither the hospitalization program, nor any other community organization or group of individuals has come forward with a contribution equal to this proposed by the medical profession.

In arriving at income limits below which the contract would provide the service at no additional fee your Committee again points out that local conditions must be carefully considered. Family buying power in Rhode Island exceeds the national average by 26.6 per cent and per capita savings are the fourth highest in the nation. In seven war bond drives Rhode Island exceeded its quota by an average of 64 per cent and at the war's end had bought more than $81 million worth of E-bonds alone.

Sales Management, in its Survey of Buying Power shows the average family buying income (gross income less income tax) for Rhode Island for 1946 to be $4,307, and the per capita income $1,188, both figures being well above the national average.

In proposing the utilization of private insurance companies to offer a wide coverage on a competitive basis the Committee has not lost sight of the fact that the primary purpose of the Society's studies has been for the extension of medical service to persons in the lower income group. We have noted with interest that press reports, editorials and public comments, other than those by the Society, have discussed insurance for everyone, whereas the medical profession has consistently maintained that the greatest concern should be to offer aid to those whose income is limited and for whom a major illness necessitating a surgical operation involves an expenditure for which funds have not been budgeted or saved.

Since Rhode Island is one of the most highly industrialized of all states we can turn to the studies of the manufacturing industries for some index of average weekly earnings of workers, since employment in manufacturing industries represents 50 per cent of all workers. In 1946 the average weekly earnings in this group was $41.79, and for the first six months of this year it has been $45.04. Thus the individual average annual earning in 1946 was $2,173.08, and for 1947 on the basis of the first six months, $2,342.08.

Therefore, it is apparent that the proposal of the Committee that the annual family income limits for complete indemnity be set at $2,000 for the individual and at $3,000 for the family is liberal, and certainly goes far above what might be determined by any basis as a low income group. A family income beyond these limits would mean that the surgical indemnity fee would be paid towards the physician's total bill with the patient liable for an additional fee, if any.

Schedule of Indemnities

The master schedule of indemnity benefits as originally accepted by the House of Delegates when negotiations were under consideration with the Hospital Service Corporation of Rhode Island a year ago has been used by the Committee. The schedule has been carefully reviewed in conference discussions with physicians of major insurance companies and it has been amended slightly to clarify some of the procedures listed. The schedule is more liberal than most schedules now followed by insurance companies, and therefore, it is advantageous to the patient-subscriber.

continued on next page

In a great many states anesthesia and radiology are included under the Blue Cross hospitalization contract. They are not included in Rhode Island. The Committee, after careful study, has agreed that radiology does not constitute a surgical benefit as such under the program proposed and therefore it recommends that it be omitted from the schedule. However, the Committee believes that anesthesia, especially when done in the hospital, should be provided for under the surgical plan even though its inclusion adds appreciably to the basic premium charge. Provision is also made in the schedule for payments to surgical assistants when the maximum amount set forth for the operative procedure exceeds $49.

Recommendations

Of paramount importance to the Committee has been the task of developing not a single plan, but a Rhode Island Medical Society Program to embrace any insurance policy that will meet the minimum standards set forth by the Committee in the best interests of the public. Hours of study have been given to the consideration of the manner by which this might be accomplished.

After consideration of the legal as well as the practical aspects, the Committee believes that the objectives can be attained in the following manner:

The Committee recommends that the House of Delegates approve

(1) a revised statement of objectives and principles, and minimum standards of coverage (attached as Schedule A),

(2) the master schedule of indemnity benefits (attached as Schedule B), and

(3) a physicians' agreement (attached as Schedule C)

After such approval, all insurance companies duly licensed in the State of Rhode Island would be invited to submit their policy forms which they propose to offer in accordance with the principles laid down by the House of Delegates. Upon such submission, the appropriate representatives of the Society (and it is recommended that a new Committee on Health Insurance be organized by the House of Delegates for this purpose) would review each policy, and if they found that the benefits in the policy meet the minimum standards of coverage and that the promotion and sale of the policy will contribute toward the attainment of the objectives of the Society, the policy would be approved in all respects except for the premium rates, and the company would be authorized to use the statement, "the benefits provided in this policy are accepted and approved by the Rhode Island Medical Society" on the policy and in advertising and promotional literature in connection therewith.

The Committee recommends that every member of the House of Delegates study each of the attached schedules carefully and come to the meeting fully familiar with them. They have not been abbreviated so that they will be studied in their entirety.

Conclusion

In view of the foregoing your Committee recommends that the House of Delegates consider this complete report for possible adoption in order to increase the extent to which voluntary insurance against the cost of medical care is made available to the people of the state of Rhode Island.

We recognize that the program will have its flaws. But we are confident that time and experience will improve and strengthen the program and extend the coverage on a competitive low cost basis.

We know that the insurance will necessarily have to be sold at the beginning on a group contract basis, just as was the hospitalization insurance. But we are encouraged by the fact that our proposal is the first to our knowledge that has attracted the interest and support of all the major insurance groups in the nation, including life insurance companies offering disability coverage, thus indicating that groups of ten or more, and ultimately individuals, may be subscribers under the program.

The fundamental concern of the medical profession is the prevention of sickness and disability, and the alleviation and cure of ill health.

As members of the community the medical profession are faced with the same identical economic problems of life as any other citizens. We are conscious of the costs of all the necessities of life of which medical care is but one. We have continually pointed out the many community problems influencing the standard of health and contributing to the total cost of medical care.

As members of the community we are conscious of the economic pattern that governs the lives of the people. Others of our members have pointed out before that good health is for the most part a natural heritage, and therefore the necessity of including a provision in the family budget for the costs to protect that heritage must not be overlooked.

This proposal which we recommend to the Society for adoption, and which we sincerely believe will find a ready response from the insurance industry of America, and which we hope will strike an equally responsive chord with the people of this State, is presented as a contribution to the

economic welfare of the community in which we live and work. It represents a sincere and honest effort on the part of the medical profession to aid not only those in the lower income group, but all the people, to budget for the unexpected and therefore often catastrophic results from disabilities necessitating surgical procedures for the restoration of good health.

ROCCO ABBATE, M.D., *Chairman*
CHARLES J. ASHWORTH, M.D.
J. MURRAY BEARDSLEY, M.D.
CHARLES L. FARRELL, M.D.
ARCADIE GIURA, M.D.

SCHEDULE A

Objectives and Principles of the Rhode Island Medical Society's Program for Voluntary Prepaid Non-Occupational Surgical and Obstetrical Insurance

The Rhode Island Medical Society (hereinafter sometimes referred to as the "Society") establishes as its objectives:

(1) To increase the extent to which voluntary insurance against the cost of medical care is made available to the people of the State of Rhode Island;

(2) To increase the effectiveness of such insurance through the voluntary cooperation of its members;

(3) To make such insurance available at the lowest practicable cost under competitive conditions; and

(4) To safeguard the physician-patient relationship deemed necessary by the Society to maintain and improve the high standards of medical care in the State of Rhode Island.

In order to attain such objectives the Society hereby sponsors a program of prepaid surgical and obstetrical insurance on the following principles:

(1) Injuries compensable under the Workmen's Compensation Law will not be covered in this program.

(2) The attached Master Schedule of Surgical Indemnities shall serve as a standard for use in connection with this plan where services are rendered up to and including a semi-private level, including such extra services as are deemed necessary by the surgeon; such Schedule is subject to change by the Society as conditions and experience warrant.

(3) The Society shall make a determined effort to obtain the consent of its members to participate in the plan. Participation shall mean the doctor's agreement with the Society to accept for a minimum of one calendar year the amounts in the Indemnity Schedule as full payment for the procedures listed therein for persons coming within the defined income group and their dependents insured under policies endorsed by the Society, as hereinafter set forth; provided such persons authorize that the benefits be paid by the insurance carrier direct to the physician.

(4) The Society shall make a determined effort to interest all duly licensed insurance companies and the Blue Cross in underwriting this plan. (Insurance company as hereinafter used refers to such a duly licensed insurance company or the Blue Cross.)

(5) Persons who shall receive surgical service for the indemnity fee listed in the Master Schedule of Surgical Indemnities include (a) individuals whose gross incomes do not exceed $2,000 per year and whose gross aggregate family incomes do not exceed $3,000 per year, and (b) individuals with dependents whose gross aggregate incomes do not exceed $3,000 per year, at the time of disability. Persons whose gross incomes exceed such limits shall have such indemnity fee applied towards the physician's total bill with such persons liable for any additional fee charged by the physician. These income limits are subject to change by the Society from time to time as warranted by conditions and experience.

(6) Each insurance company desiring to have its policies approved under this program shall submit to the Society the policy form or forms it plans to offer with the endorsement of the Society; such policy forms may include coverage in excess of that required by the Society for endorsement; provided, however, no policies shall be sold under this program before January 1, 1948.

(7) The Society shall review the policy forms and, if it finds that the Indemnity Schedules and other provisions in such policies, except as hereinafter noted, meet the minimum standards of coverage and believes that the promotion and sale of such policies will contribute toward the attainment of the objectives of its program, the Society shall forthwith grant its consent to the use by the company of the statement "The Benefits in this Policy are Accepted and Approved by the Rhode Island Medical Society" on such policy forms and in its advertising and promotional literature to be used in connection therewith; for the sake of simplicity, some of the less frequent types of procedures may

continued on next page

be omitted from the printed fee schedule in such policy forms, with the understanding that the attached Indemnity Schedule shall govern for unprinted procedures.

(8) All advertisements and promotional literature involving the Society's name shall be submitted to the Society at least fourteen days (excluding Sundays and holidays) before its intended use and the use of any such material shall be subject to disapproval of the Society on reasonable notice to the company.

(9) The Society shall be under no obligation whatsoever to review the premium rate or rates of those policies submitted for its approval under this program, since it is the desire of the Society to permit such rates to seek their natural levels through competition; however, the Society may request any company to furnish it with the rates at which the policies are to be or are being offered to the public and the company shall comply with such request within a reasonable time.

(10) The Society may request experience and enrollment figures from any insurance company and the company shall comply therewith in reasonable time, but such statistics shall not be made public in any manner which will identify any of the statistics with any one insurance company without that company's consent.

(11) An insurance company whose policies are approved under this plan shall not interfere with the insured's free choice of a physician.

(12) The Society shall not interfere (except as hereinafter provided in Paragraph 16) with an insurance company's rights and obligations under the terms of the policy form endorsed by the Society, provided, however, that payments made by the insurance company under such policy for procedures not listed in the attached Indemnity Schedule shall be subject to review by the Society.

(13) An insurance company whose policies are approved under this plan may at any time, upon fourteen days' prior written notice to the Society thereof (Sundays and holidays excluded), cease to issue its policies with the Society's endorsement. Thereafter, such company shall not use the endorsement of the Society on any new policies issued or in advertising or promotional literature in connection therewith. In such event the Society's endorsement of all outstanding policies of said company shall nevertheless continue until the next following anniversary date of issue of such policies.

(14) The Society may at any time, upon fourteen days' prior written notice to an insurance company (Sundays and holidays excluded), withdraw its consent to the use of its endorsement on any policy form and in advertising and promotional literature in connection therewith. In the event of such withdrawal (a) the company shall cease forthwith to use such endorsement on all new policies on such forms and in advertising and promotional literature in connection therewith; (b) the Society's endorsement of all outstanding policies of said company on said form shall nevertheless continue until the next following anniversary date of issue of such policies; and (c) the company shall have no cause of action against the Society except upon proof of malice.

(15) An insurance company whose policies are approved under this program shall not be prevented thereby from issuing policies which are not endorsed by the Society so long as such policies and the advertising and promotional literature in connection therewith do not use the name of the Society.

(16) An insurance company whose policies are approved under this plan shall not make it a condition of selling any policy form endorsed by the Society that the prospective policy holder shall take any additional or other form of insurance.

(17) A Health Insurance Committee of the Society shall confer with the insurance companies on problems which arise in connection with this program, for the purpose of taking appropriate action upon administrative matters, complaints of persons insured and/or participating doctors, and, if so authorized, to act in the name of the Society to carry out these principles.

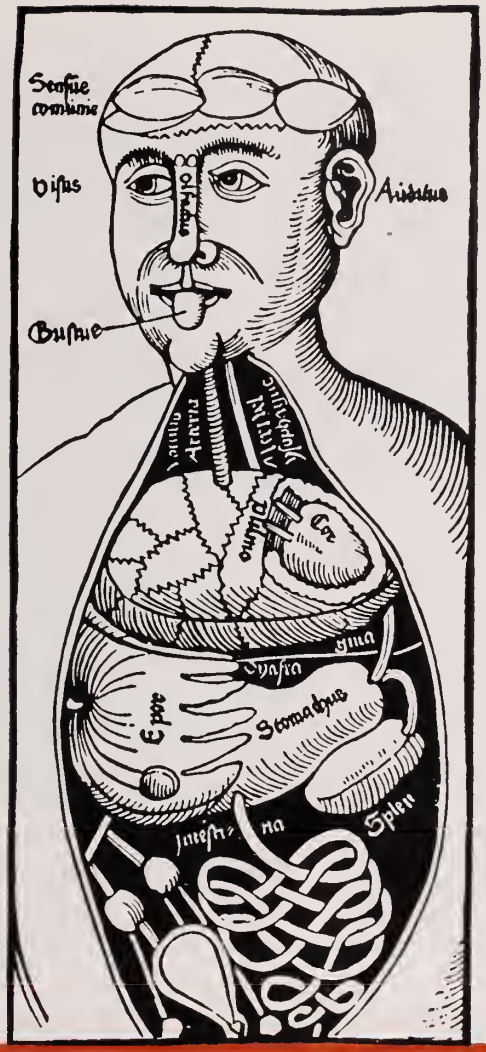


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IN 1516:

Anatomic illustrations were crude; knowledge of the anatomy and the treatment of diseases of the heart and thoracic organs were extremely limited.

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SCHEDULE B

MASTER SCHEDULE OF SURGICAL INDEMNITIES

(*Including usual pre- and post-operative hospital care*)

I. *MULTIPLE PROCEDURES*

When more than one operation is performed at one time, payment will be made for each in accordance with this Schedule, subject to a maximum total of $150. Furthermore, the maximum total with respect to all operations due to the same or related cause which are performed during a continuous period of disability shall be $150. For this purpose all procedures performed through the same incision shall be considered one operation, and operations that are not separated by three months shall be deemed to have been performed during "a continuous period of disability".

II. *UNLISTED PROCEDURES*

In addition to the procedures listed in this Schedule, amounts shall be payable for cutting operations performed in a legally constituted and operated hospital while the patient is confined, other than as "out-patient". The maximum amounts for such procedures shall be determined in amounts consistent with those listed.

GENERAL SURGERY

Infections and Traumata

Abscesses incision and drainage, Furuncles excepted	$ 5.00
Deep cervical abscess	25.00
Carbuncle	25.00
Ulcer, surface excision	10.00
Tendon, repair, one primary	25.00
each additional	10.00
Maximum	100.00
Septic finger (tendon sheath involvement)	15.00
Septic hand (tendon sheath and compartments)	75.00
Lacerations, extensive, including debridement	25.00

Cysts

Cyst, sebaceous, removal	$10.00
Pilonidal cyst or sinus	50.00
Thyroglossal cyst, removal	100.00
Bronchial cyst, removal	100.00

Tumors

Tumors, benign external, removal	$10.00
Tumors, benign, removal deep	25.00
Epulis, removal	15.00
Parotid tumor, removal	75.00
Epithiolioma of face, surgical removal	25.00
Cancer of tongue, (resection or removal)	100.00
Same with neck dissection	150.00
Cancer of lip (local operation)	35.00
Same with neck dissection	125.00

Biopsy

Biopsy, superficial	$ 5.00
Biopsy, bone or bone marrow	15.00
Biopsy, needle aspiration	5.00

Glands

Glands, superficial, removal	$10.00
Dissection glands of neck, deep chain	100.00
Radical Axilla or groin	100.00

Thyroid

Thyroidectomy, subtotal	125.00
Ligation preliminary to thyroidectomy	25.00
Thyroidectomy, two-stage, subtotal (with or without ligation) Complete procedure	150.00
Parathyroidectomy	150.00

Breasts

Breast abscess, drainage	$25.00
Breast cyst or abscess, aspiration	10.00
Breast tumor, benign removal	35.00
Breast, radical removal, including axillary dissection	125.00
Breast, simple removal	75.00

Miscellaneous

Ligation, saphenous vein, low, including retrograde injection, if done	$25.00
Ligation, saphenous vein, high, (and combined) including retrograde injection, if done	40.00
Extensive varicose veins, one leg (Multiple ligations on same or successive days)	50.00
Same, bilateral	100.00
Toe nail, ingrown, removal radical	20.00
Stone, submaxillary or parotid duct	25.00
Removal of submaxillary salivary gland	50.00
Injection, varicose veins, complete procedure	25.00

ENDOSCOPY

(When preliminary and related to surgical service only)

Bronchoscopy, diagnostic, preceding surgery	$25.00
operative	50.00
Cystoscopy	
Observation (preceding surgery)	15.00
Ureteral catheterization	20.00
Operative	35.00
Gastroscopy	25.00
Laryngoscopy	
Diagnostic (by Laryngoscope)	10.00
Operative	25.00
Peritoneoscopy	25.00
Sigmoidoscopy and biopsy	10.00
Esophagoscopy	25.00

SPECIAL SURGERY

Thoracic Surgery

Pneumolysis	$75.00
Pleura, paracentesis	10.00
Empyema, closed drainage	25.00
Empyema, rib section	75.00
Phrenic nerve, crushing	25.00
Thoroceplasty (First stage or partial)	75.00
(Complete)	150.00
Thoracoplasty (complete)	150.00
Lobectomy	150.00
Aneurysmorraphy	150.00
Induction of artificial pneumothorax	25.00
Refills	5.00

Abdominal Surgery

Abdomen, paracentesis	$10.00
Herniotomy, single inguinal, femoral or umbilical	100.00
Herniotomy, bilateral inguinal or femoral	125.00

continued on page 746



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NEO-SYNEPHRINE SULFATHIAZOLATE... a true chemical compound in clear solution 0.6%... provides the decongestive effect of ¼% Neo-Synephrine plus ample bacteriostatic action, with a minimal concentration of sulfathiazole... clears the nasal airways for greater breathing comfort... tends to limit the spread of infection caused by secondary invaders.



NEO-SYNEPHRINE WITH PENICILLIN... vasoconstrictor and antibacterial for use in acute and chronic sinusitis. Supplied as a combination package—when mixed each cc. contains at least 1000 units of penicillin in ¼% Neo-Synephrine Hydrochloride. Special buffer holds the pH of the mixed solution at 6.0... enhances the stability of penicillin in solution, helps restore normal acidity of nasal mucous membranes.

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Herniotomy, hiatus or diaphragmatic	150.00
Herniotomy, ventral or incisional	100.00
Esophageal diverticulum	125.00
Gastrotomy or gastrostomy	100.00
Gastrectomy	150.00
Gastro-enterostomy	125.00
Peptic ulcer, perforated, closure	100.00
Peptic ulcer, subtotal gastrectomy	150.00
Pyloric stenosis (Rammstedt's in infant)	100.00
Intestines, anastomosis	125.00
Intestines, (small) resection	125.00
Adhesions, freeing of	100.00
Laparotomy	75.00
Colon, resection	150.00
Colostomy	75.00
Appendectomy	100.00
Diverticulum, intestinal	100.00
Appendiceal, abscess, drainage	100.00
Subdiaphragmatic abscess	100.00
Cholecystectomy	125.00
Biliary surgical drainage—common duct and cholecystectomy	150.00
Common duct, resection or reconstruction	150.00
Cholecystostomy	100.00
Cholecysduodenostomy	125.00
Pancreas, drainage	100.00
Splenectomy	150.00

Proctology

Hemorrhoids, injection treatment, complete procedure	25.00
Hemorrhoid, thrombosis, incision	5.00
Hemorrhoids, internal	35.00
Hemorrhoidectomy	35.00
Fistulectomy, single, excision of tract	50.00
multiple, excision of tract	75.00
Fistulectomy, excision of fistulous tract	25.00
Fissurectomy	10.00
Polypectomy	25.00
Abscess, ischio-rectal or peri-rectal drainage	20.00
Carcinoma of rectum, resection	150.00
Perianal abscess, drainage	5.00
Prolapsed rectum, repair	100.00

Urology

Circumcision, infant not requiring anesthesia	5.00
Circumcision, excepting the above	15.00
Urethrotomy, external, except meatotomy	50.00
Urethrotomy, internal	50.00
Prostatic abscess	35.00
Prostatectomy, perineal	125.00
Prostatectomy, suprapubic—one stage including vasectomy	125.00
Prostatectomy, suprapubic—two stage including vasectomy	150.00
Prostatectomy, transuretheral	100.00
Punch operation with suprapubic drainage	100.00
Perineoplasty with uretheral repair	75.00
Hydrocele, radical operation	50.00
Litholapaxy	50.00
Epididymectomy	50.00
Vasectomy (When not preliminary to prostatectomy)	25.00
Vesiculectomy	100.00
Varicocelectomy	50.00
Orchidopexy—One stage	75.00
Two stage	125.00
Orchidectomy simple	50.00
With gland dissection	100.00
Cystotomy or Cystostomy	75.00
Cystostomy with fulguration	100.00
Cystectomy	150.00
Ureter transplantation, single	100.00
bilateral	150.00
Bladder tumor, diverticula, etc. (resection)—open operation	125.00
Uretero-lithotomy	100.00
Nephrotomy	125.00
Nephrostomy	125.00
Nephrectomy	125.00
Nephropexy	100.00
Pyelotomy	100.00
Plastic on pelvis and ureter	125.00
Heminephrectomy	125.00
Excision and suture of urinary fistula (suprapubic)	50.00
(vaginal)	100.00
Penis amputation	75.00
Same with groin dissection	150.00
Plastic Hypo—and epispadias	125.00
Meatotomy	5.00
Caruncle excision	15.00
Caruncle fulguration	15.00

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Skull

Simple fracture (non-operable) with brain injury	$35.00
Depressed	75.00
Compound	150.00
Brain tumors	150.00

Brain Injuries; operable type

Extradural hematoma	$150.00
Subdural hematoma	150.00
Exploratory Trephination	
One side	50.00
Two sides	75.00
Intracortical clot	150.00
Arterio-venous fistula, intracranial	150.00

Spinal Cord

Section of anterior or posterior roots	150.00
Decompressive laminectomy	150.00
Removal of or exploration for an extruded nuclues, pulposus or ruptured intervertebral disc	150.00

Peripheral Nerve

Suture, decompression, or transplantation of single nerve	25.00
Each additional	10.00
Maximum	100.00
Pneumonenchephalogram	25.00
Ventriculogram	35.00
Spinal cord tumors	150.00
Operation for pain associated with malignancy or similar untreatable disease requiring intraspinal nerve sections or cordotomy	150.00

Miscellaneous

Section of sensory root for 5th nerve neuralgia	150.00
Section of vestibular nerve for Meniere's disease or aural vertigo	150.00
Operation for scalenus anticus syndrome	50.00
Craniotomy for brain abscess	150.00
Craniotomy for conditions not listed herewith	150.00
Bilateral orbital decompression	150.00
Choroidectomy for hydrocephalus	150.00
Excision of meningocele	75.00
Lumbar puncture (with fracture or operative work only) (diagnostic excluded)	5.00

Sympathetic System

Unilateral lumbar sympathectomy	$100.00
Bilateral lumbar sympathectomy	150.00
Resection of pre-sacral plexus	150.00
Bilateral, thoraco lumbar sympathectomy	150.00

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Miscarriage (curettage)	25.00
Caesarean section, vaginal	100.00
Caesarean section, abdominal	100.00
Pregnancy, ectopic	100.00

GYNECOLOGY

Bartholin's gland, incision	$ 5.00
Bartholin's gland, excision	25.00
Labial tumors and cysts, removal	20.00
Atresia of vagina, plastic	50.00
Fistula, recto-vaginal	100.00
Fistula, vesico-vaginal	100.00
Cul-de-sac, drainage	35.00
Cauterization or conization of cervix	10.00
Dilatation with or without curettage or cauterization	25.00
Uterine polyp removal with dilatation and curettage	25.00
Cervical polyp removal	5.00
Trachelorrhaphy	35.00
Cervix amputation	50.00
Oophorectomy or resection of ovaries	100.00
Hysterectomy	150.00
Myomectomy	100.00
Uterine flexions, etc., correction, (plus surgery of tubes and ovaries)	100.00
Same with vaginal plastic work	125.00
Salpingectomy	100.00
Salpingoophorectomy	100.00
Cystocele	50.00
Rectocele	50.00
Combined cystocele and rectocele	75.00
Prolapse operations (interposition, Manchester)	100.00
Vulvectomy	75.00
With groin dissection	150.00

OPHTHALMOLOGY

Foreign body, removal, within anterior or posterior chamber	$100.00
Cornea, parecentesis	20.00
Conjunctival suture	15.00
Conjunctival flap for corneal ulcer, etc.	25.00
Chalazion (excision, single	10.00
multiple	25.00
Lachrymal sac, removal	50.00
Entropion or ectropion, Ziegler's puncture	30.00
Entropion or ectropion, plastic operation	50.00
Entropion or ectropion, plastic operation grafts or flaps	75.00
Symblepharon, release	30.00
Pterygium	25.00
Corneal Ulcer—Cauterization	5.00
Corneal ulcer, deliminating keratotomy	25.00
Tarsorrhaphy, orbicularis paralysis	30.00
Ptosis, (single)	50.00
Strabismus, one or more muscles	75.00
Cataract, needling	40.00
Cataract, removal	100.00
Iridectomy	50.00
Glaucoma, filtration operation	100.00
Enucleation or evisceration	50.00
Same and implantation	75.00
Tumor, exenteration of orbit	100.00
Dacryocystorhinostomy	100.00
Detached Retina	125.00

OTOLOGY

Aural Polyp	10.00
Paracentesis tympani	10.00
Mastoidectomy, acute single	100.00
Mastoidectomy, acute bilateral	125.00
Mastoidectomy, radical single	150.00
Fenestration for otosclerosis	150.00

NOSE AND THROAT

Nasal polyps, removal	10.00
Antrum, Caldwell-Luc	50.00
Ethmoidectomy	35.00
Frontal sinus, radical	100.00
Turbinectomy	10.00
Submucous resection	50.00
Palatorrhaphy	100.00
Tonsillectomy and adenoidectomy	
Under 15	25.00
Over 15	35.00
Laryngectomy	150.00
Tracheotomy	50.00
Malignant disease, accessory sinuses (Radical Operation)—One sinus	100.00
Multiple	150.00
Malignant disease, tonsil and pharynx (Radical Operation)	100.00
Antrum puncture and irrigation	5.00
Antrum window	50.00

ORTHOPEDIC

Spinal fusion	$150.00
Cartilage of condyle of femur, removal of	75.00
Bone plate, removal of	25.00
Talipes	50.00
Semilunar cartilage, removal from joint	75.00
Tenotomy, simple, open	25.00
closed	15.00
Claw foot, except bone surgery—see foot stabilization	50.00
Coccyx, excision of	25.00
Arthrotomy, any major joint	75.00
Hallux Valgus, single radical operation	50.00
exostectomy	25.00
Osteomyelitis, sequestrum removal	25.00
Hallux valgus, bilateral radical operation for	75.00
Foot stabilization	150.00
Hammer toe, operation for	35.00
Arthrodesis of knee, hip, shoulder or elbow	150.00
Torticollis, operation for	75.00
Arthroplasty, any major joint	150.00
Hip joint, resection	150.00
Any other major joint, resection	100.00
Any joint, resection of, fingers or toes	25.00

AMPUTATIONS

Shoulder, Disarticulation	$125.00
Upper arm	50.00
Forearm	50.00
Hand	50.00
Finger, single	15.00
Each additional	10.00
Hip	125.00
Thigh	75.00
Knee	75.00
Leg	75.00
Toe	15.00
Each additional	10.00
Foot	50.00
Elbow	75.00
Scapulo thoracic amputation	150.00

DISLOCATIONS — CLOSED

Carpal bone, one	$25.00
Each additional	10.00
Clavicle	25.00
Elbow	25.00

continued on page 752



Pyribenzamine

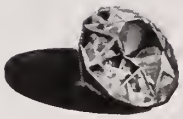
High-concentration Elixir Pyribenzamine hydrochloride now provides a second administration form of this proved antihistaminic. Containing 20 mg. of Pyribenzamine hydrochloride per 4 cc. (teaspoonful), the Elixir has obvious advantages in special cases, notably in infants and children, and in adults who prefer liquid medication.

Scored tablets of Pyribenzamine also facilitate small dosage when indicated—the 50 mg. tablets are easily broken to provide 25 mg. doses.

Council Accepted. PYRIBENZAMINE hydrochloride ® (brand of tripelennamine hydrochloride)

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$35.00 SET—Specially selected assortment of 112 allergens including 83 foods, 10 incidentals, 9 epidermals, and 10 fungi in vials containing sufficient material for at least 30 tests each. The physician may make his own selection from our current list, which will be sent upon request.

$9.75 SET—Stock selection of 64 food and 16 epidermal and incidental allergens, in vials containing sufficient material for at least 10 tests each.

Each set accompanied by a supply of N/20 sodium hydroxide for use in making the tests.

Advantages of Dry Allergens:

- Retain potency indefinitely
- No refrigeration required
- Safety
- Economy
- Simplicity in use
- Reduced likelihood of false reactions

1. Feinberg, S. M.: Quart. Bull. Northwestern Univ. M. School 20: 398 (1946)

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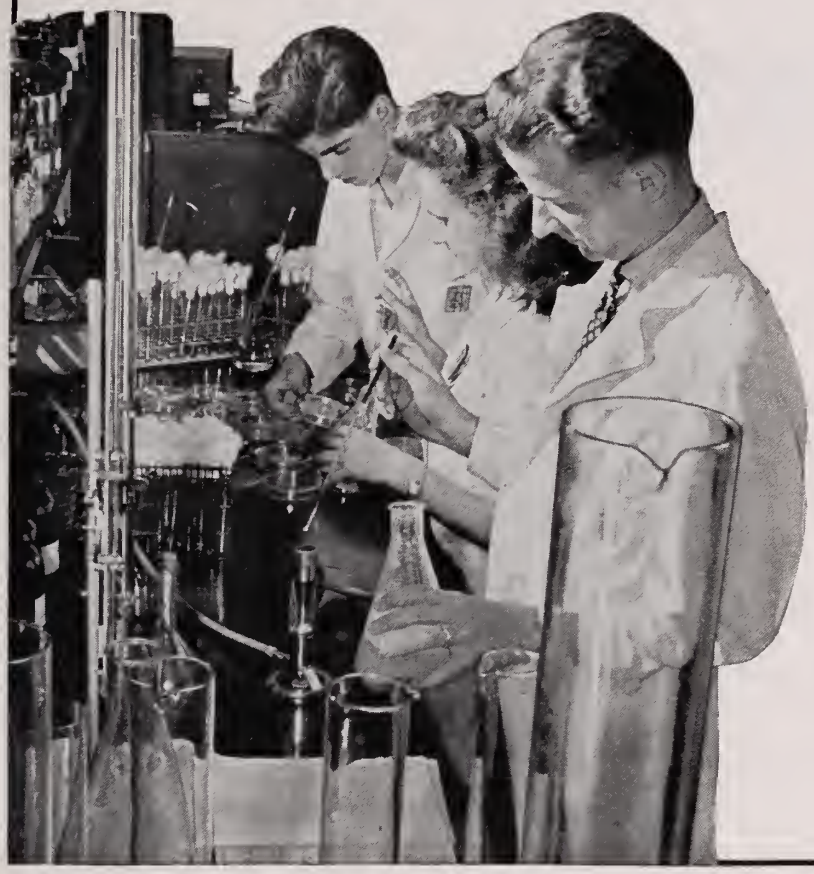
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Merck research has been directly responsible for many important contributions to the synthesis, development, and large-scale production of individual vitamin factors in pure form.

In a number of instances, the pure vitamins may be considered to be products of Merck research. Several were originally synthesized in The Merck Research Laboratories, and others have been synthesized by Merck chemists and collaborators in associated laboratories.

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Metacarpal bone, one	15.00
Each additional	5.00
Metatarsal bone, one	15.00
Each additional	5.00
Patella	15.00
Rib	10.00
Shoulder	25.00
Tarsal bone, one	25.00
Each additional	10.00
Thumb	10.00
Toe, one	5.00
Each additional	5.00
Vertebra, one or more	100.00

SIMPLE FRACTURES — CLOSED

Lower jaw	$25.00
Carpal bone, one	25.00
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Clavicle	25.00
Coccyx	10.00
Femur	75.00
Tibia or fibula or both	50.00
Potts' or Cottons Fracture	75.00
Finger, one	10.00
Each additional	5.00
Humerus	50.00
Metacarpal bone, one	15.00
Each additional	10.00
Metatarsal bone, one	15.00
Each additional	10.00
Patella, closed	25.00
Nasal bone or bones—reduction	25.00
Pelvis	75.00
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Rib, one or more	10.00
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Scapula	25.00
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Each additional	5.00
Vertebra, one or more	100.00
Os Calcis or Astragalus, or both	50.00

OPEN REDUCTIONS AND COMPOUND FRACTURES—

For compound fractures the maximum amount will be one and one-half times, and for fractures or dislocations requiring an open operation will be twice the amount shown for the corresponding simple fractures or dislocations, but in no case more than $150.

ADDITIONAL BENEFITS

In addition to the maximum amount set forth above, amounts will be allowable for Anesthesia, Transfusions, and Surgical Assistants as follows:

ANESTHESIA

To licensed physicians other than surgeons or assistant:

Where surgical indemnity is:	Anesthesia indemnity is:
Under $50	$10.00
50 to 99	15.00
100 to 150	20.00
Tonsillectomy	$8.00

Night emergency, minimum indemnity is to be $10.00

Transfusion, blood or plasma, (when given during any operative procedure) (Limit of two) $ 5.00

SURGICAL ASSISTANTS

When the nature of an operation is such that the services of an assisting licensed physician are necessary:

When surgical indemnity is:	Assistant's indemnity is:
$50 to $99	$10.00
100 to 150	15.00

SCHEDULE C

PARTICIPATING PHYSICIAN OF THE RHODE ISLAND MEDICAL SOCIETY

I hereby subscribe as a participating physician under the program sponsored by the Rhode Island Medical Society for voluntary prepaid surgical and obstetrical insurance, and the added insurance covering anesthesiology, as accepted and approved by the Rhode Island Medical Society.

In consideration of my being listed as such "Participating Physician", I hereby agree that my charges for the services included in the Master Schedule of Surgical Indemnities, as approved by the Rhode Island Medical Society under such program, and rendered to the insured or his dependents, shall not exceed the amount specified therein, provided the insured is (a) an individual whose gross income does not exceed $2,000 per year and whose gross aggregate family incomes do not exceed $3,000 per year, or (b) an individual with dependents whose gross aggregate income does not exceed $3,000 per year, at the time of disability.

I understand that persons whose gross incomes exceed such limits shall have such indemnity applied towards my total bill with such persons liable for any additional fee charged by me.

I understand that nothing in this agreement is intended to affect the relationship between the physician and his patient nor to restrict the physician in the exercise of his right to refuse to treat any patient for appropriate professional reasons.

I further agree to abide by the rulings of the Society's Committee on Health Insurance which will function under this program for the express purpose of facilitating any administrative problems that may arise.

I agree not to withdraw my consent as a participating physician prior to January 1, 1949.

.....M. D.

Address:

Date:

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smaller dosage

treatment of inflammatory enteric diseases

'SULFATHALIDINE' *phthalylsulfathiazole*, developed by the Medical Research Division of Sharp & Dohme for treatment of inflammatory conditions of the intestine, is clinically nontoxic and effective in *smaller dosage* . . . 0.05 gm. to 0.1 gm. per kilogram of body weight daily. • 'SULFATHALIDINE' *phthalylsulfathiazole* maintains a high bacteriostatic concentration in the gastrointestinal tract, markedly alters the bacterial flora, and profoundly reduces Escherichia coli, clostridia and related organisms. Moreover, 'SULFATHALIDINE' *phthalylsulfathiazole* is effective even in the presence of a watery diarrhea. • Administered recently to 100 patients with inflammatory diseases of the intestine, 'SULFATHALIDINE' *phthalylsulfathiazole* was effective in the treatment of 90.* The clinician reported:

"It is my impression that phthalylsulfathiazole is less toxic and more bacteriostatic than any intestinal agent used previously and that, because it has these properties, smaller doses of the drug may be used to advantage."*

Indications: Ulcerative colitis, regional ileitis and ileojejunitis, and as an adjunct to intestinal surgery. • Supplied in 0.5-Gm. compressed tablets, bottles of 100, 500 and 1,000. Sharp & Dohme, Philadelphia 1, Pa.

*J. A. M. A. 129:1080. December 15, 1945.

'SULFATHALIDINE'

SHARP & DOHME

Phthalylsulfathiazole

HOSPITAL ASSOCIATION OF RHODE ISLAND

EFFECT OF HIGH PRICES ON HOSPITALS

CARL A. LINDBLAD, Director, Roger Williams General Hospital, Providence

ALL HOSPITALS in recent years have found it necessary to make drastic increases in charges for services rendered to patients. As all physicians requiring hospital care for their patients are vitally interested in this subject, it is well to acquaint the medical profession with the problem that confronts hospital management.

During the war years when prices were stable and under control and when hospital bed occupancy was at a high level, our hospitals were in better financial condition than for many years preceding the war. Since price control has been dropped, higher labor and material costs has again placed many hospitals in the red, despite higher rates to patients and liberal contributions. Rates on interest derived from invested endowment funds has steadily declined and this income will no longer meet the mounting deficits. Large bequests from individuals is no longer to be expected and is not likely to be a factor in the future. This is due to the very high income and estate taxes prohibiting liberal bequests. It will therefore be necessary for the hospitals to secure the greater part of needed income from service rendered to patients.

Much has been published in the press lately on the high costs of modern hospital care. The figures given below are taken from information furnished by the Roger Williams General Hospital to its Board of Trustees in order that the Trustees might intelligently consider the problem. The facts are probably applicable to all of our hospitals.

PRICE COMPARISON

The following comprise the more heavily used items and are only a few of the many commodities used in the hospital. The prices are for the month of July, and unit costs are still on the increase and at the time of printing this issue of the Journal will no doubt be considerably higher:

	PRICE 1941	PRICE 1947	% INCREASE
Fuel Oil	.0345 gal.	.058 gal.	68%
Bed Sheets	8.50 doz.	23.66 doz.	179%
Gauze Sponges, 4x4	4.80 M	11.08 M	131%
Gauze Dressing Rolls	2.05 C-yds.	4.80 C-yds.	134%
Cut Gauze	2.05 "	4.80 "	134%
Cotton Balls	1.45 M	3.05 M	110%
Surgeons Gowns	16.60 doz.	31.00 doz.	87%
Canned Tomatoes, #10	4.75 "	11.90 "	150%
Coffee	.41 lb.	.74 lb.	49%
Fresh Milk	.08½ qt.	.13½ qt.	59%
Butter	.41 lb.	.74 lb.	80%
Eggs, fresh	.34 doz.	.72 doz.	112%
Beef, hinds	.21½ lb.	.58 lb.	170%

The Hospital Pay Roll has increased 80% during the same period, and if the hospitals are to meet the accepted industrial standard of a five day, forty-hour week, the Pay Roll would increase an additional 25%.

CHARGES TO PATIENTS

The hospitals have been reluctant to increase its charges to patients and have delayed increases in the hope that the situation might change. The charges have therefore not kept pace with increasing costs as will be noted from the percentage figures below.—

Single Rooms, (Private) 33% to 40% higher
Two Bed (Semi-private) 45% to 54% higher
Four Bed Rooms 75% higher

The wards are necessarily increased in rate to a larger extent as the costs of caring for a patient in the ward is but very little less than for the patient occupying a private room, and the rates have always been maintained at a considerable loss even before the present high price era. The per capita cost per day for each patient ranges from $11 to $14 in the hospitals in Rhode Island.

THE ROGER WILLIAMS GENERAL HOSPITAL SCHOOL OF NURSING

This school has been more fortunate than others in our area in securing applicants for admission. The number of students accepted is limited by the teaching facilities and the clinical material available, and in order to maintain standards prescribed for an accredited school, and to insure each student a well rounded and efficient course, the number accepted is usually set at 36 each year. An agreement with Rhode Island State College obligates the hospital to accept a limited number of students who are students in the Five Year program now availvale at State College.

continued on page 756



chemically similar to natural estrogens

ESTINYL (ethinyl estradiol) is "chemically similar to natural estrogen."[1] It is more active *orally* than any other synthetic or natural estrogen known today. ESTINYL is the first estradiol preparation that. is efficacious by mouth in really minute amounts. It provides the economy inherent in low dosage. Five-hundredths of a milligram daily is sufficient to relieve the average menopausal patient. ESTINYL, closely allied to the primary follicular hormone, does more than mitigate vasomotor symptoms. ESTINYL quickly relieves the common nervous manifestations and bodily fatigue, and replaces them with a sense of emotional and physical fitness.

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Average menopausal symptoms: One 0.05 mg. ESTINYL Tablet daily. Severe menopausal symptoms: Two or three 0.05 mg. ESTINYL Tablets daily. Many patients may be maintained in comfort with 0.02 mg. ESTINYL Tablet daily after initial control of estrogen deficiency.

Packaging: ESTINYL TABLETS of 0.05 mg.—pink, coated tablets and 0.02 mg.—buff, coated tablets, bottles of 100, 250 and 1,000.

1. Bickers, W.: Am. J. Obst. & Gynec. 51:100, 1946.

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Simple, Reliable, TABLET Methods for Quick Detection of

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Tablet method for rapid detection of occult blood in feces, urine and other body fluids. Bottles of 60 tablets.

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Tablet, *no heating* method for quick detection of albumin. Bottles of 36 and 100 tablets.

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Tablet, *no heating* method for detection of urine-sugar.

Laboratory Outfit.

Plastic Pocket-size Set.

Clinitest Reagent Tablets 12x100's and 12x250's for laboratory and hospital use.

AMES COMPANY, Inc.

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HOSPITAL ASSOCIATION NOTES

continued from page 754

Thirty-six students were admitted to the School on September 15th. They were carefully selected from 89 high school graduates who filed applications for admission to the School this year. In February, 1948, ten students in the five-year course at R. I. State College will join them in classes at the hospital.

The College students who began their program at the College in the Fall of 1945 have already completed basic College courses in physiological, biological and social sciences. During the current Summer they completed a ten weeks period of preclinical experience at Roger Williams General Hospital.

After their fifth semester of academic study at the College the program will include a 120 weeks period of clinical study and experience in the Hospital and at affiliating institutions. At the end of their course, they will receive a Bachelor of Science degree and a diploma in nursing from Rhode Island State College.

Miss Louise White, R.N., M.A., Director of the Division of Nursing, Rhode Island State College, has general supervision of the program which has been developed in consultation with the Committee on Nursing Education of the State Department of Health. The faculty at the College and the Faculty at the Roger Williams General Hospital School of Nursing work together very closely in planning and carrying out the clinical program.

New appointments to the Faculty of the School of Nursing during the current year were: Miss Lydia Blaser, R.N., M. A., Director of Nursing; Miss A. Rose Fratantuono, R. N., B.S., Assistant Director of Nursing; Mrs. Olive L. Young, R.N., B.S., Instructor in Science; and Miss Claire M. Montminy, R.N., Assistant Instructor in Nursing Arts. Miss Florence M. Weigner, R.N., B.S., has been appointed Educational Director.

Miss Agnes V. Davis, R.N.

announces the opening of a

CONVALESCENT HOME

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CHARLES V. CHAPIN HOSPITAL

The Charles V. Chapin Hospital is well known throughout the country for its work in contagious diseases. During recent years, there has been a rapid trend towards specialization and fulfillment of the requirements set up by the various boards for the different specializations. The care and treatment of contagious diseases is not recognized as a specialty in itself. For this reason, during the last few years, it had become increasingly difficult to obtain doctors for this training. The solution to this problem was relatively easy.

The Charles V. Chapin Hospital is ideally equipped and staffed for a children's hospital. In July, 1946, approval for the training of residents in pediatrics by the American Board of Pediatrics and the Council on Medical Education and hospitals of the American Medical Association was granted. Certain requirements of the board which could not be filled by the hospital were arranged for by affiliation with the following outside assignments: Well-Baby Clinics conducted by the State Department of Health and Providence Health Department; New-Born Babies, Pawtucket Memorial Hospital; Child Guidance Clinics, Emma Pendleton Bradley Home, and Mental Hygiene Clinic. A new modern medical library for the staff has been established with every necessary book and periodical available. At the present time, there is a great demand for pediatric appointments at the Chapin which, we hope, and have no reason to doubt, will continue indefinitely.

The Charles V. Chapin Hospital, since its establishment, has always had a salaried resident staff. This policy does entail some expense, but has many advantages. An experienced, trained man in pediatrics and contagious diseases is always on duty in the hospital and sees every case soon after admission day or night. The proper treatment instituted without delay is in many cases life saving.

It might be well to remind the medical profession that cases may be admitted to this hospital from anywhere in the state.

A new training course for nurses in the psychopathic department has been established.

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Decholin produces hydrocholeresis, flushing the bile ducts, removing accumulated mucus and inspissated bile.

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DOHO in realizing the need for a potent, topical, well tolerated ear medication, yet mindful that no one formula could be suitable for all conditions . . . devoted every facility and scientific resource to the development and perfection of AURALGAN and OTOSMO-SAN. Each has its sphere of usefulness . . . each has been tested and clinically proven in many thousands of cases. *Reprints and substantiating data sent on request.*

EACH A SPECIFIC . . . both effective!

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is a scientifically prepared, completely water-free Glycerol (DOHO) having the highest specific gravity obtainable, containing antipyrine and benzocaine . . . which by its potent decongestant, dehydrating and analgesic action provides effective relief of pain and inflammation.

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THE JOHN F. KENNEY ANNUAL CLINIC OF
THE MEMORIAL HOSPITAL INTERNES' ALUMNI ASSOCIATION
at The Memorial Hospital, Pawtucket, Rhode Island on
Wednesday, October 29, 1947

MORNING SESSION (9:30 a.m. to 12:55 p.m.) HENRY B. MOOR, M.D., *Chairman*

9:30– 9:35	GREETINGS	J. LINCOLN TURNER, M.D., *President Internes' Alumni Association*
9:40– 9:50	"SKIN GRAFTING"	BERT S. JEREMIAH, M.D.
9:55–10:05	"RESULTS OF THE TREATMENT OF ANGIOMA AT THE TUMOR CLINIC OF THE MEMORIAL HOSPITAL"	WILLIAM B. COHEN, M.D.
10:10–10:20	"HEMORRHAGE IN OTO-LARYNGOLOGY"	FRANCIS B. SARGENT, M.D.
10:25–10:45	"FRACTURES OF THE SHAFT OF THE TIBIA — TYPES AND TREATMENTS" — (Bone grafts and non-union)	ROBERT T. HENRY, M.D. *Collaborator:* JOHN H. GORDON, M.D.
10:50–11:10	"WILM'S TUMOR" — REPORT OF TWO CASES IN THE SAME FAMILY	MIHRAN A. CHAPIAN, M.D. *Collaborator:* EARL F. KELLEY, M.D.
	"LACERATION OF THE SCROTUM AND DISPLACEMENT OF TESTICLE"	STANLEY SPRAGUE, M.D.
11:15–11:35	"SUBACUTE BACTERIAL ENDOCARDITIS" — REPORT OF A CASE TREATED SUCCESSFULLY WITH PENICILLIN (34 months after treatment)	JACOB GREENSTEIN, M.D. *Collaborator:* RAYMOND W. YOUNG, PH.D.
11:40–12:05	"SYMPOSIUM ON RHEUMATIC HEART DISEASE"	EARL J. KELLY, M.D. BANICE FEINBERG, M.D. FRANCIS CORRIGAN, M.D. *Collaborator:* JOHN F. KENNEY, M.D.
12:10–12:35	"VISUALIZATION OF OBSTETRICAL TECHNIQUES USED IN TEACHING STUDENT NURSES"	J. LINCOLN TURNER, M.D. HENRY E. TURNER, M.D.
	"MODERN TRENDS IN OBSTETRICAL ANESTHESIA" (Low spinals, saddle block and Tohey technique)	WALTER J. DUFRESNE, M.D. HOWARD W. UMSTEAD, M.D.
12:40–12:55	"SYMPATHECTOMY IN THE TRAUMATIZED LIMB"	HANNIBAL HAMLIN, M.D. *Collaborator:* JESSE P. EDDY, 3d, M.D.
1:00– 2:00	LUNCHEON	

AFTERNOON SESSION (2:00 to 5:00 p.m.) GUY W. WELLS, M.D., *Chairman*

1. "BLOOD AND PLASMA IN SURGICAL EMERGENCIES." DR. FIORINDO A. SIMEONE — *Assistant Prof. of Surgery, Harvard Medical School, and Assistant Surgeon, Massachusetts General Hospital.*
2. "THE USE OF STREPTOMYCIN IN TUBERCULOSIS." DR. DONALD S. KING — *Lecturer in Medicine, Harvard Medical School, and Physician to the Massachusetts General Hospital.*
3. "PRESENT CONCEPTS IN TREATMENT OF CANCER OF THE CERVIX." DR. C. LANGDON PARSONS — *Instructor in Surgery, Harvard Medical School, and Visiting Surgeon, Massachusetts General Hospital.*
4. "MANAGEMENT OF HEART FAILURE." DR. EDWARD F. BLAND — *Instructor in Medicine, Harvard Medical School, and Associate Physician, Massachusetts General Hospital.*

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY

Report of Meeting Held on September 15, 1947

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Monday, September 15, 1947. The meeting was called to order by Dr. Ruggles at 8:35 p.m.

The following Delegates were in attendance:

Rocco Abbate, M.D.
Charles J. Ashworth, M.D.
Robert Baldridge, M.D.
Philip Batchelder, M.D.
Alex M. Burgess, M.D.
James Callahan, M.D.
Peter Pineo Chase, M.D.
Paul C. Cook, M.D.
G. Edward Crane, M.D.
Frank B. Cutts, M.D.
Morgan Cutts, M.D.
William P. Davis, M.D.
Donald DeNyse, M.D.
Charles L. Farrell, M.D.
David Freedman, M.D.
Isaac Gerber, M.D.
Henry Hanley, M.D.
Robert Henry, M.D.
William A. Horan, M.D.
Russell R. Hunt, M.D.
Albert H. Jackvony, M.D.
Walter S. Jones, M.D.
Louis I. Kramer, M.D.
Herman A. Lawson, M.D.
Earl J. Mara, M.D.
James M. McCarthy, M.D.
Louis Morrone, M.D.
John C. Myrick, M.D.
Joseph C. O'Connell, M.D.
Patrick I. O'Rourke, M.D.
Arthur H. Ruggles, M.D.
Daniel V. Troppoli, M.D.
Frederick A. Webster, M.D.

Others present were Dr. Arcadie Giura, member of the Surgical Study Committee, Mr. Charles Williamson, Legal Counsel for the Society, Mr. Henry Locke, Chairman of the Insurance Committee, and Mr. John E. Farrell, Executive Secretary.

Dr. Ruggles announced that the meeting would be devoted entirely to the Surgical Study Plan, and he expressed thanks to the Committee for the hours of time and thought they had spent on the work for the Society.

A copy of the supplemental report was distributed to each member and Dr. Abbate explained that it had not been mailed to the House as the regular report had been because it was completed too late to have it reach each member prior to the meeting. Dr. Abbate read the Supplemental Report explaining it as he went along.

Dr. Abbate explained that the supplemental report dealt wholly with conferences with the Blue Cross and he made it clear that the Committee had given them all the help possible.

Dr. Ruggles asked for questions or comments on the Supplemental Report. Dr. C. L. Farrell moved that the report be laid on the table. The motion was seconded and passed.

Since the House had received copies of the main report Dr. Abbate noted several corrections made by legal counsel, and then presented the report section by section. Discussion of various sections is summarized as follows:

INCOME LIMITS

Dr. W. S. Jones posed the question of whether the income limit was to mean gross income, or income after taxes had been deducted. The point was discussed and it was noted that in all plans the income limit is for gross income.

Dr. Baldridge raised the question of estates, citing as an example a man who has no actual income but who has an estate of $66,000. This man can have his cancer removed as a poor man. He stated that he believed this to be a gross injustice to the medical profession. Dr. Abbate pointed out that there would be a committee to settle the disputes such as illustrated when they do arise.

Dr. Jones pointed out further that the doctor "didn't have to take the patient." There is nothing in the plan that makes it mandatory to take any patient.

There was discussion relative to "semi-private" patients, which again brought up the fact that estates should be judged and limited. Dr. Ruggles stated that these problems could be better solved after the program has started and experience had been gained as to what present the real problems.

Radiology

Dr. Batchelder felt that Radiology should be included in the program as it is in most of the sixty-four plans already in practice. He remarked that particularly in fracture work it was going to be difficult to explain to the patient that X-ray was not included.

Dr. Abbate stated that the Committee felt that in the beginning it should leave out Radiology as not being an actual surgical procedure; then as the program progresses add extras such as Radiology. Dr. Farrell pointed out to the House that it was mostly a question of getting $15 worth of treatment and having to raise the premium rates, and that in most cases it would be easier for the individual to pay for X-ray out of his own pocket than to have to raise the premium for this one additional benefit.

continued on page 762

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HOUSE OF DELEGATES REPORTS

continued from page 760

There was lengthy discussion in which Dr. Farrell stated again that it wasn't worth it to give the patient only $15 worth of X-ray in one year and up the cost of the plan 10 per cent. To Dr. Gerber's statement that the patient won't know the difference, Dr. Farrell stated that the patients have to be taught that the plan does not cover *everything,* but only certain things. The Committee put X-ray in the schedule in the beginning, but after much discussion and thought the Committee came to the conclusion that it was best to leave it out. Anesthesiologists and surgical assistants are included, so the patient would have money of his own to cover other expenses such as X-ray.

Dr. Gerber wanted to know if there would be sufficient publicity so that the public would be aware of these omissions. Dr. Abbate answered that there would be. He said the Committee had done everything it could to keep this plan at as low a cost as possible and when the Society puts in a medical plan X-ray certainly would be included.

Dr. Batchelder moved that radiology, according to the schedule submitted by the Surgical Committee in 1946, be included. The motion was not seconded.

Schedule A

Dr. Batchelder pointed out that the use of "Fee" Schedule is an error. It should be "Indemnity" schedule, which it is called in Schedule B. However, it is referred to several times in Schedule A as "Fee." On a show of hands the majority wanted "Indemnity" inserted instead of "Fee" each time it occurred.

Dr. Baldridge opened discussion of Objective 2 relative to services being rendered on a semi-private basis. He stated that he thought this required further definition and clarification. The matter was discussed in detail and it was the general agreement that the section should be amended to explain that minimum semi-private care is meant and not extra services not usually given. It was further the opinion of the House that the semi-private basis should include anything that is considered necessary by the surgeon.

A discussion on limiting unearned income (estates) was held. It was brought out that there are some estates that earn nothing. It was the opinion that such questions and problems will have to be settled by the special committee to be named.

Dr. Davis asked what "Eligble" means. Dr. Abbate answered that "Eligible" means for "full coverage."

continued on page 764

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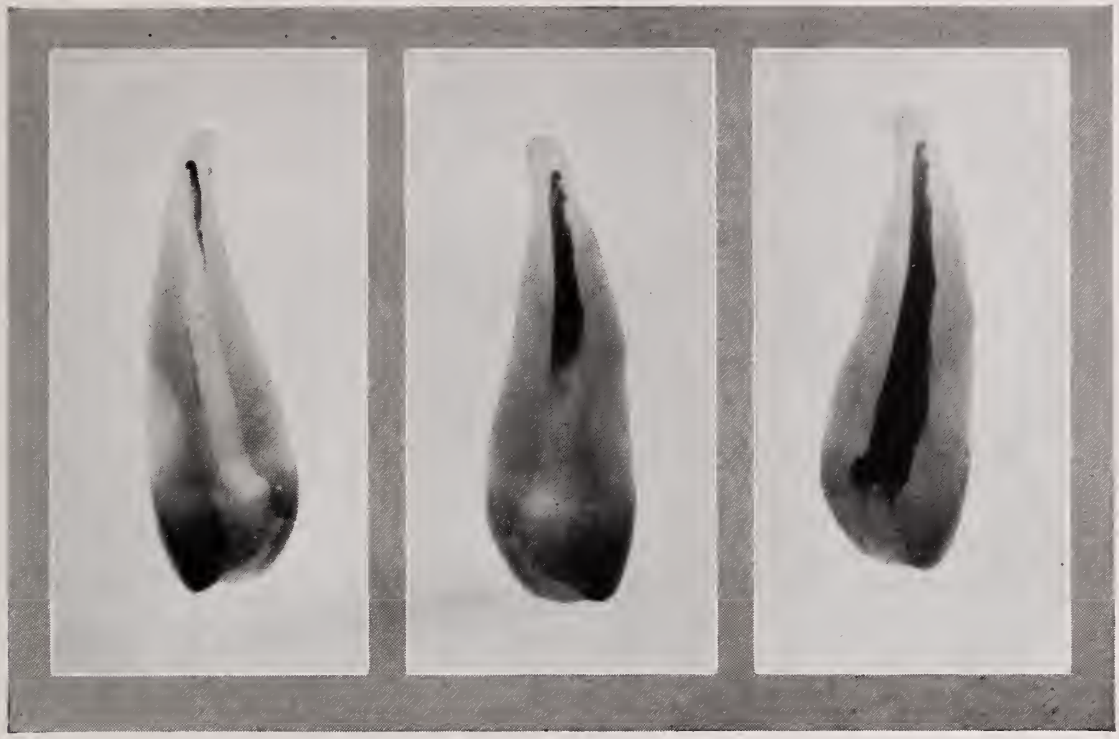
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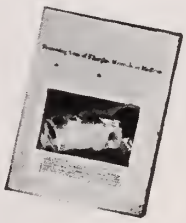
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HOUSE OF DELEGATES REPORTS
continued from page 762

On point 10 Mr. Williamson stated that there would be the addition of "and the company shall comply therewith after reasonable time," to be inserted.

In Sections 13 and 14 corrections were noted to read, "the Society's endorsement of all outstanding policies of said company on said form shall continue until *the next following anniversary of the date of issue of such policies.*" ("Until expiration thereof" being deleted.)

Pre- and Post-Operative Care

Dr. Davis raised the question of how long post-operative care should be continued. Under the proposed plan, there is no limit.

Dr. Ashworth stated that the committee had thought a long time about the question and decided that pre- and post-operative care meant the care that was incidental to hospitalization and the ordinary care that was necessary afterwards.

There was discussion about the cases that required long post-operative care and Dr. Farrell stated that the physician knows what is meant and if a limit is put in black and white it goes that way and no other.

Dr. Louis Morrone moved that post-operative care be limited to three weeks. There was discussion in which some of the members felt that certain cases should get special care and other members felt that care should be limited. Dr. Morrone amended his motion to read that post-operative care be three weeks while in the hospital; and one visit after surgery that was done in the office.

On a hand vote, ten were in favor of the motion and fourteen opposed.

Dr. Davis moved that this motion be referred back to the Committee for rewording and reclarification on the basis of the discussion at the meeting. The motion was seconded.

Dr. Mara stated that the people who are going to be covered by this insurance, the low-income group, are used to the Workmen's Compensation Act and they understand the word "usual," and further ,the Committee did not want the motion thrown back at them but apparently wanted the House to settle the question.

The motion was withdrawn.

Dr. Davis moved that where there is no specification in the schedule of indemnity benefits as to the extent of care to be provided for the amount listed for any particular procedure, it shall be taken to include the hospital examination, pre- and post-operative *hospital* care. The motion was unanimously accepted.

Dr. Davis amended his motion to provide that Schedule B of the new report relating to the master schedule of surgical indemnities be amended by the addition of the word "hospital" after the word "post-operative" relating to the usual pre- and post-operative care. The motion was seconded and passed.

Transfusions

The question was brought up as to who gets the $5 transfusion fee. It was suggested that the schedule be made specific and state that the amount be added to the anesthetist's charge. After discussion it was decided that this would be clear if just the heading "Transfusions" were deleted, and the transfusions fee be brought up as part of the "Anesthesia" paragraph.

Surgical Assistants

Some of the members thought that surgical assistants should get as much as anesthetists. A discussion followed. Dr. Hunt moved that transfusions be taken out entirely and the amount put on the surgical assistant's fee. After further discussion and debate in which it was pointed out that although the anesthetist does get a higher fee, very often he is held up after the operation and loses one or two succeeding operations, thereby not actually getting any higher fee in the long run than the surgical assistant who is free to go after the operation.

Dr. Jones moved that the indemnity schedule be approved and the House pass on to further business. The motion was seconded and on a voice vote passed.

Schedule C

Dr. Jones stated that the schedule should be amended so that the eligible group is taken care of under it. A discussion followed, and Dr. Jones then moved that the schedule be approved as amended. The motion was seconded and on a voice vote unanimously passed.

Dr. Ashworth moved that the entire Report be adopted as amended, and Dr. Burgess amended the motion by adding that the Committee be commended for its excellent work. The complete motion was seconded and passed unanimously.

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Dr. Ashworth moved that all members of the House of Delegates sign as active participating physicians. A discussion followed in which it was questioned whether men who are not surgeons should sign up since they will not be able to participate actively in the plan. It was generally agreed that it would be a good morale booster if every Member signed up, whether he came under the plan or not.

After discussion Dr. Ashworth withdrew his motion and it was agreed that all the members of the House of Delegates present express their intention of signing as participating physicians by their endorsement of the plan.

New Health Insurance Committee

Dr. Henry moved that "A health Insurance Committee be formed composed of the present committee, and one additional member from each district society not at present represented. At all times there will be two from the Providence Medical Association and one from each of the other district societies. They shall be elected for staggered terms, two new, and two taken off each year. Each district will nominate one or more members and the President of the Rhode Island Medical Society will elect the Committee.

The motion was seconded and unanimously passed.

Physician Cooperation Question

Dr. Jones expressed doubt as to how the Providence physicians will take to the plan and he expressed the opinion that a ballot should be circularized asking if the physicians intended to sign.

Dr. Abbate moved that the President be empowered to send each member of the Society a copy of the report as amended by the House of Delegates and that a blank of Schedule C be sent to them for approval by signing and returning. The motion was seconded and passed.

Members were agreed that each district society have a meeting for the express purpose of discussing the surgical plan. Dr. Ruggles stated that the committee should educate the district societies.

Dr. Farrell raised the question of whether the Committee has the right to act for the Society. Dr. Burgess moved that the Surgical Plan Study Committee be authorized to act under the adopted plan for the Society. The motion was seconded and passed.

Publicity

Dr. Davis moved that the Committee Chairman, his Committee, and the President, be authorized to disseminate publicity on the report and proposed program. The motion was seconded and passed.

The meeting adjourned at 12:05 a.m.

Respectfully submitted,
MORGAN CUTTS, M.D.
Secretary



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BOOK REVIEW

A HISTORY OF THE AMERICAN MEDICAL ASSOCIATION 1847-1947, by Morris Fishbein, M.D. W. B. Saunders Company, Philadelphia, 1947, $10.00

This massive volume of 1226 pages is not a history so much as a compilation of the widespread activities of the American Medical Association touching every branch of medical science and its relation to the public interest. As such, it is a valuable reference book. The Association is the brain child of Nathan Smith Davis, M.D. In the best American tradition, he was born in a log cabin in New York State and his struggles to obtain an education, and the hardships of the early years of practice are reminiscent of an Horatio Alger hero. After practicing in several small towns in his native state, he served for a year or two as Demonstrator of Anatomy in the College of Physicians and Surgeons in New York City until 1849 when he was called to the chair of Physiology and Pathology at Rush Medical College, Chicago. He spent the remainder of his life in that city and died, full of honors, at the age of 87, having practised 67 years. Dr. Davis had a flair for organization and believed that the numerous county and state medical societies of the country should join in a representative national organization in order to elevate the standards of medical education, licensure and public health; to maintain high ethical standards, to oppose charlatanism; to make available a better quality of medical service and to promote clinical and scientific investigation. These standards are still the ideal of the medical profession everywhere, and have not been greatly improved upon since his time. Dr. Fishbein has traced the accomplishments of the American Medical Association in pursuit of the above ideals with a detailed description of the achievements attained at each annual session. Biographies of the recipients of the Distinguished Service Medal occupy a small section of the book since they are only seven in number. Of especial interest are the biographies of the 101 Presidents of the Association. In almost every instance, the incumbent of this high office has been preeminent in his chosen field as well as a worker for higher scientific and ethical standards and improved medical organization. The history of the various councils and bureaus and the publications of the Association are discussed in separate chapters, each written by an authority on his particular subject. The chapters on the libel suits brought against the Association and the indictment and trial by the Federal Government make interesting reading and are well illustrated. In a recent issue of the New York Sunday Times — notably hostile to medical organization — the reviewer of this book praises the

continued on page 768



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BOOK REVIEW

concluded from page 766

scientific accomplishments of the medical profession in a few brief sentences, but devotes most of his review to a bitter denunciation of the sociological activities of organized medicine, with no reference to the factual data contained in this volume.

ROLAND HAMMOND, M.D.

CHOLINE CHLORIDE IN CIRRHOSIS OF THE LIVER

concluded from page 728

Patient was admitted to the hospital for the fourth time for a check-up on June 16, 1947, almost three years since the last paracentesis. (See Laboratory Sheet.) At the beginning of her illness, five years ago, she weighed 104 pounds. She now weighs 114 pounds and looks like a woman thirty years of age instead of her real age of forty-five, in spite of having 106 paracenteses.

The only positive pathological findings — liver is palpable two and a half fingers below the ziphoid and laterally is lost under the costal margins. The spleen is palpable one finger below the costal margin and on deep inspiration extends to three fingers. The blood pressure is 120 over 80, pulse 72, temperature normal and respiration normal. Discharged June 18, 1947, as an arrested case of cirrhosis of the liver.

SUMMARY. The earlier a high protein, high vitamin B diet plus added Choline is instituted, the quicker the sick liver will be brought under control.

BIBLIOGRAPHY

[1] Wendell H. Griffith and Nelson J. Wade—II. The Interrelationship of Choline, Cystine, and Methionine in the Occurrence and Prevention of Hemorrhagic Degeneration in Young Rats. The Journal of Biological Chemistry, Vol. 132, No. 2, Page 635, February, 1940.

[2] G. O. Broun and R. O. Muether, Treatment of Hepatic Cirrhosis with Choline and Diet Low in Fat and Cholesterol, J. A. M. A. 118: 1403, April 18, 1942.

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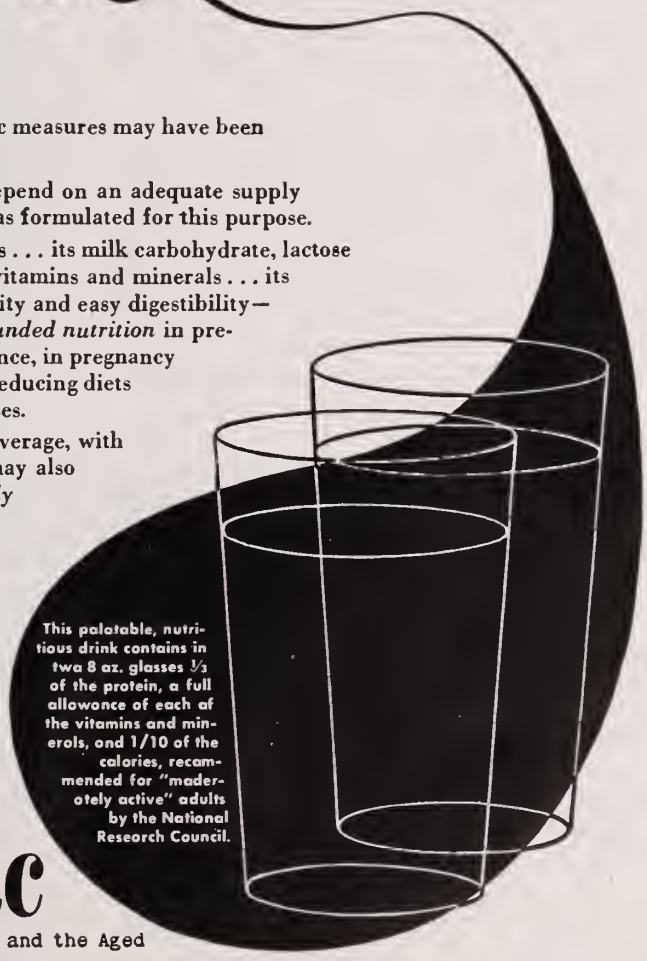
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(1) The case, or series of cases, must have been studied by the contestant during his hospital service.

(2) The manuscript must be endorsed by the visiting man under whom the work was performed. This endorsement consists merely of a statement that the work described in the report was done on his service. The statement will be enclosed in a sealed envelope containing the name of the contestant. On the outside of the envelope will be placed a number, letter or motto which will be written in the same manner on the manuscript in place of the author's name.

(3) The manuscript must be typewritten and submitted in duplicate to the Executive Secretary of the Providence Medical Association during the hospital service of the contestant or within six months after the date of completion of service.

(4) When a report is judged worthy by the Contest Committee it will be accepted for the competition, and the envelope containing the name of the contestant will be opened. The contestant later will present his report in person before the Providence Medical Association at one of its regular meetings as arranged by the President. He will be notified well in advance of the date and hour of the meeting.

(5) Manuscripts received between January first and July first of any year will be considered for presentation at the October, November or December meetings. Those received after July first will be considered for presentation at the February, March, April, May or June meetings of the following year.

(6) Presentations should be straightforward reports of cases and should not include a review of the literature nor a general discussion of the subject illustrated.

(7) Contestants are not expected to submit illustrations with their manuscripts but are encouraged to use slides and tables if they so desire in their presentations before the Association.

(8) Two or more men may collaborate in submitting a report, in which case the presentation will be made by one of them and any prize money will be equally divided.

(9) In making awards the Committee will consider the following three factors, giving approximately equal weight to each:

Medical interest and value of the material presented.

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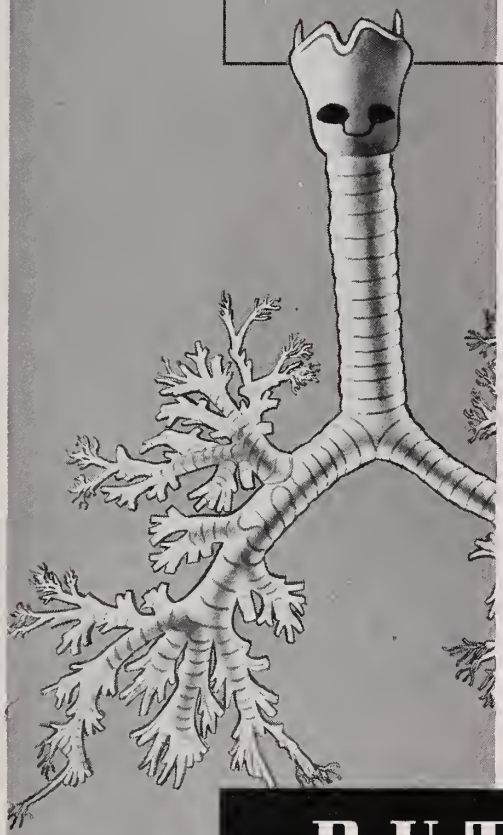
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OCTOBER 29-31

Program

WEDNESDAY, OCTOBER 29

Morning Session

8:45 Registration

9:50 Assembly called to order by Dr. Leroy E. Parkins, *Chairman*

10:00 Clinical Diagnosis of Peripheral Vascular Disease, DR. HUGH MONTGOMERY

10:30 Treatment of Open Wounds of the Hand DR. MICHAEL L. MASON

11:00 15-minute intermission

11:15 Streptomycin in Tuberculosis and Other Diseases DR. WALSH MCDERMOTT

11:45 Office Gynecology: Diagnosis DR. RICHARD W. TELINDE

12:15 Luncheon. Copley Plaza Hotel
National Science Foundation Legislation MR. BRADLEY DEWEY

Afternoon Session

2:00 Office Gynecology: Treatment DR. RICHARD W. TELINDE

2:30 Treatment of Peripheral Vascular Disease DR. HUGH MONTGOMERY

3:00 Principles of Management of Burns DR. MICHAEL L. MASON

3:30 15-minute intermission

3:45 Present Status of Lobotomy and Shock Therapy in the Treatment of the Psychoses DR. HARRY C. SOLOMON

4:15 Common Dermatologic Problems in Medical Practice DR. MARION B. SULZBERGER

4:45 The Use of Sulfonamides and Penicillin DR. WALSH MCDERMOTT

THURSDAY, OCTOBER 30

Morning Session

10:00 The Treatment of Infantile Diarrhea DR. L. EMMETT HOLT, JR.

10:30 Office Methods for the Diagnosis of Anal Disease (Motion Pictures) DR. LOUIS A. BUIE

11:00 15-minute intermission

11:15 Management of Diabetes Mellitus DR. HERMAN O. MOSENTHAL

11:45 Surgery of the Aged, DR. I. S. RAVDIN

12:15 Luncheon. Copley Plaza Hotel
The Problem of Cancer as Approached by the American Cancer Society
Speaker: DR. EDWIN P. LEHMAN
President, American Cancer Society

Afternoon Session

2:15 Psychiatry in Medical Practice DR. EDWARD WEISS

2:45 Office Treatment of Anal Disease DR. LOUIS A. BUIE

3:15 15-minute intermission

3:30 The Treatment of Syphilis with Penicillin DR. EVAN W. THOMAS

4:00 Problems of Nutrition in the Elderly Surgical Patient DR. I. S. RAVDIN

7:00 Dinner. Copley Plaza Hotel
Address — The Continuing Education of Physicians: A forecast of imminent changes DR. GEORGE BAEHR

FRIDAY, OCTOBER 31

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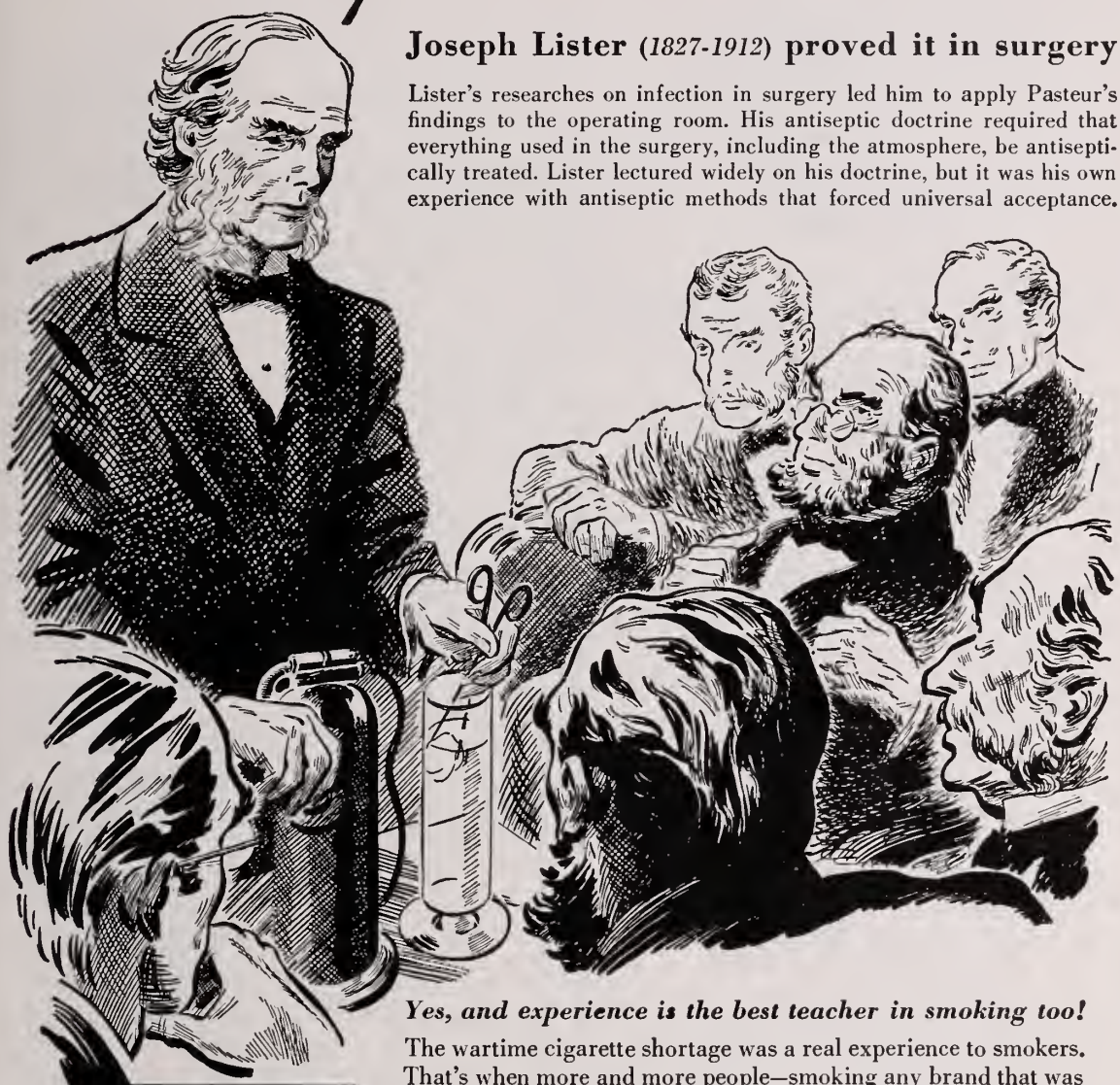
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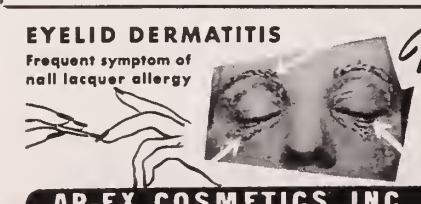
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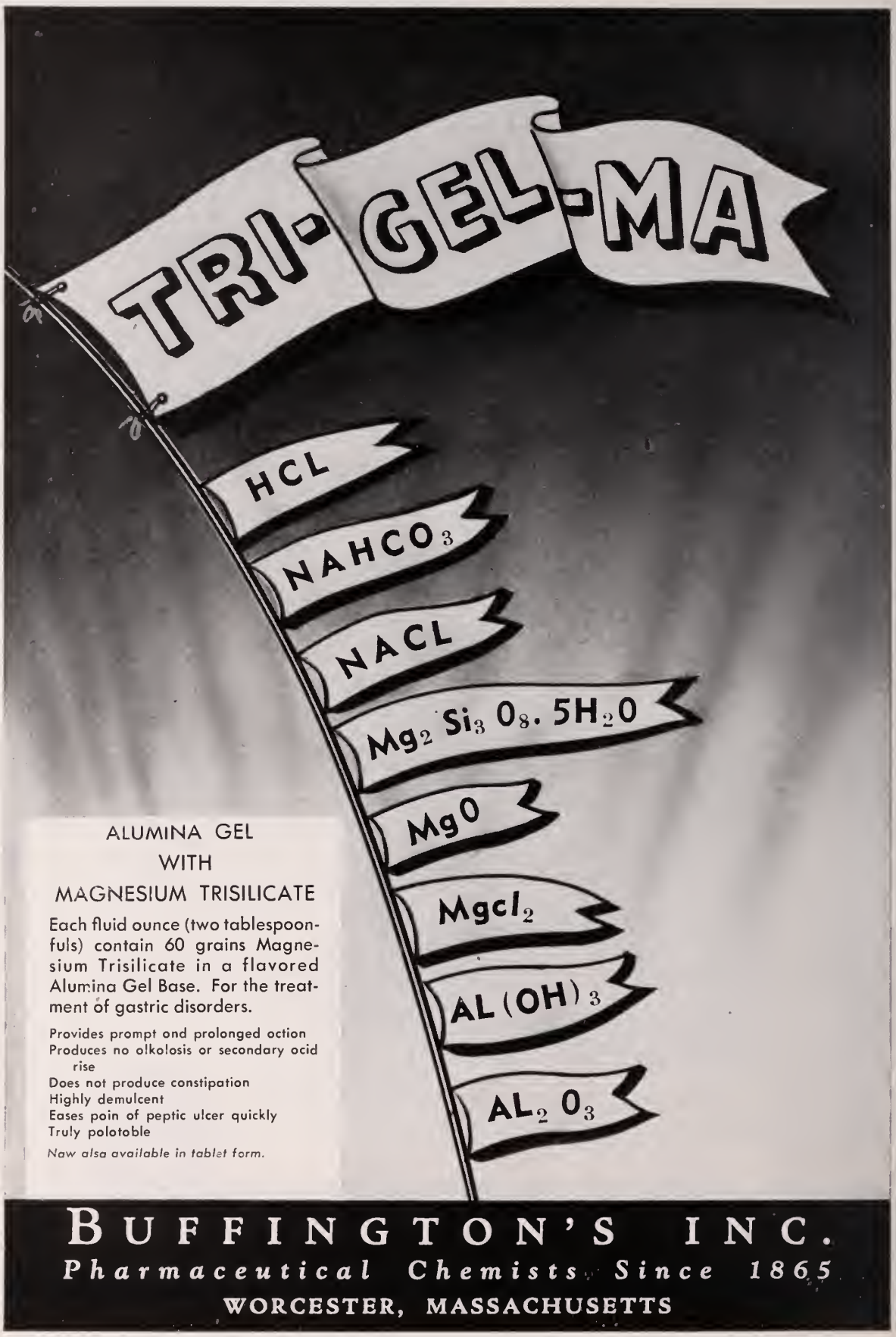
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ANTICOAGULATION THERAPY WITH HEPARIN/PITKIN MENSTRUUM IN THROMBOEMBOLIC DISEASE*

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AS BACKGROUND for the discussion of anticoagulation therapy in thromboembolic disease, experimental investigations relating to the functional pathology of thromboembolism and the rationale of heparin therapy were presented in detail. These scientific studies played an important role in the development of an effective, practical and conservative treatment program for thromboembolic disease.

Heparin/Pitkin Menstruum has been the subject of elaborate clinical observation and trial for a period of years in the prophylaxis and treatment of intravascular thrombosis[1-9]. Our composite series totals more than 450 patients who received several thousand subcutaneous deposits of heparin/-Pitkin Menstruum. Experimental investigation and clinical experience with this anticoagulation preparation has been more extensive in the field of venous thromboembolism. The knowledge thus acquired has provided the basic principles which are applied in the treatment of arterial thrombotic diseases including coronary artery thrombosis.

Treatment Program of Venous Thromboembolism

Although many methods of treatment of thrombophlebitis and/or phlebothrombosis have been proposed, three major thoughts have dominated the clinical scene during the past five years; namely, paravertebral block, vein ligation and anticoagulation therapy.

The Ochsner-DeBakey treatment[10] of thromboembolism with paravertebral block reduces the pain by relief of vasospasm. Repeated blocks are necessary but the overall length of disability and permanent disfigurement are not necessarily lessened. Papper and Imber[11] have recently presented evidence that the use of paravertebral block may be so effective in producing vasodilatation that thrombi may be liberated with resultant embolism.

While our contrary views on the matter of vein ligation have been set forth elsewhere[2,3,9] the literature abounds in articles advocating this form of therapy for venous thromboembolism.

The surgical approach to the problem of venous thromboembolism centers around ligation of the deep femoral veins, iliac veins, ovarian veins, or the inferior vena cava. Bilateral femoral vein ligation must be practiced inasmuch as with unilateral vein ligation, fatal pulmonary emboli may derive from an unsuspected thrombotic process on the contralateral side. Even this procedure, the magnitude of which is unduly minimized by present observers, does not offer absolute protection against embolization. Allen, Linton and Donaldson report 6 deaths due to emboli subsequent to femoral vein ligation in a series of 1300 patients[12]. There are, furthermore, known fatalities in which the offending embolus originated from the profunda femoris veien proximal to the site of ligation of the superficial femoral vein.

It must be stated that, although the majority of emboli derive from the peripheral veins, the initiating site may at times be the pelvic veins, for which surgical intervention, if it is to be at all effective, must perforce be a formidable procedure. Finally, in those cases of long standing thrombophlebitis, phlegmasia alba dolens, in which multiple infarcts have occurred, any surgical intervention short of vena cava ligation offers little prospect of cure. Ligation of the inferior vena cava upon a critically ill patient carries a high mor-

continued on next page

*Abstract of address delivered June 19, 1947, at Rhode Island State Medical Society Library, Providence, under the auspices of Miriam Hospital, Providence, Rhode Island.

tality[13]; Nurnberg[14] collected 526 cases of inferior vena cava ligation for puerperal sepsis with a mortality of 50.7%. Since the favorite site for thrombophlebitis in the parturient and the postoperative gynecological patient is situated in the venous plexuses about the uterus, adnexa, and pelvic veins, ligation below the femoral veins does not obliterate the focus. Finally, operative procedures which interrupt not only venous but also lymphatic channels contribute considerably to the production of edema. Ligation of the iliacs and inferior vena cava is frequently attended by late complications, permanent lymphedema of the lower extremities and neurovascular changes.

In view of the complications of the surgical approach in the treatment of thromboembolic disease, it is apparent that the anticoagulants assume prime importance. Anticoagulation therapy deals with the abnormal physiology of blood and lymph in the body. Of the anticoagulants dicumarol and heparin have been the most widely used.

Recourse to dicumarol is understandable because it can be administered orally. The effectiveness of the drug, however, is tempered by the difficulty in planning dosage schedules and more important, because of its dangerous complications[15-19]. There is great variability in the response to dicumarol, this lack of uniformity of response being present even in the same individual. Fixed dosage schedules cannot be established; patients must be individualized. The action of dicumarol is slow, from 48 to 72 hours being required before its therapeutic effectiveness is achieved. This delay in action is due to the fact that dicumarol's anticoagulation action is a reflection of its attack on the liver inhibiting the formation of prothrombin.

Due to delay in action and the variability of the patient's response, dicumarol is not always useful in the early critical stages of thrombosis or major pulmonary embolism where prompt anticoagulation effect is imperative. The delayed action and prolongation in effect after cessation of therapy are disadvantages during or shortly after operative procedures and in patients with anticipated, threatened, or actual hemorrhage. Instances have been observed in which embolism, thromboses or progression of existing venous thromboses have occurred despite low blood prothrombins induced by dicumarol[17]. Patients receiving dicumarol require daily prothrombin determinations. The use of dicumarol should not be countenanced unless there are proper laboratory facilities for prothrombin determinations by acceptable technics. The latter are time consuming and relatively expensive.

In the presence of liver disease the use of dicumarol is contraindicated. It has been attended by irreversible hemorrhage and death[18]. Transfusions of fresh blood alone do not arrest the hemorrhagic tendency occasioned by the drug. Massive dosages of Vitamin K are required which may, in turn, reinduce thrombosis[19].

In summary then, the delayed action, potential hazards, the unpredictable treatment failures, and the requisite complicated but indispensable laboratory procedures militate against dicumarol as the anticoagulant of choice.

The properties of heparin which render it uniquely applicable in thromboembolic disease may briefly be enumerated; it prevents, with the aid of a plasma cofactor, the conversion of prothrombin to thrombin; it forms with serum albumen a strong antithrombin; and, finally, it prevents the formation of thromboplastin from platelets[20]. The accepted knowledge concerning the mechanism of the action of heparin is graphically portrayed in Fig. I.

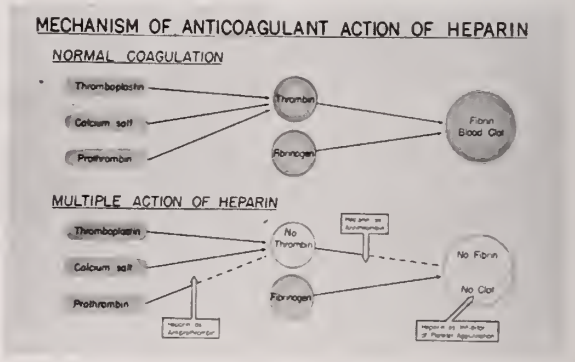


FIGURE 1

Mechanism of anticoagulant action of heparin

Heparin is a mucoitine polysulphuric acid. The most potent preparations of heparin according to Jorpes[21] contain 45% of sulphuric acid which results in an exceedingly strong negative electric charge. No other compound of high molecular weight in the mammalian body has such a strong electric charge. Apparently, heparin exerts its action through this charge. This seems to be supported by the neutralizing effect of basic protamine, which has the property of promptly counteracting the action of heparin. The multiple effect of heparin on thromboplastin, prothrombin, thrombin, the haemolytic complement, isohaemagglutinins and different enzymes is most readily explained as a loading and unloading of electric charges on the proteins concerned. The properties of heparin predicate the fact that a clot, regardless of its site or stage, cannot propagate in the presence of heparin. However, what happens to the clot which is already present?

It has been possible to determine experimentally in animals at what stage of clot formation heparin administration results in solution of the clot and

what effect heparin has on the organized clot[3, 22, 23].

Briefly, studies on the effect of heparin in experimental venous thrombosis have yielded the following data:

1. Red cell clots not organized and containing a minute amount of fibrin (sludge stage) disappear completely under heparin therapy.

2. Heparin therapy maintains patent adjacent collaterals and tributaries which ordinarily would become involved in the thrombotic occlusive process. These compensatory collaterals often become as large as the originally occluded vessel. This phenomenon has not been observed in control animals. It may be assumed, though not necessarily proved, that these processes also occur in obstructed lymphatics.

Until recently the routine use of aqueous heparin has been limited by the expense, by the huge amount of drug required in the individual case and by the cumbersome method of administration, which requires a continuous venoclysis or repeated daily intravenous dosage. A slower and more equable distribution of heparin was obtained by incorporating the drug in the Pitkin Menstruum developed to regulate the rate of release of water soluble drugs injected intramuscularly or subcutaneously[1].

A detailed description of the heparin/Pitkin Menstruum preparation has been presented in previous publications[1-9], including the rationale, indications and contraindications for its use, its advantages, the technic of subcutaneous administration and the various formulas (*Table I*) which are now available.*

As pointed out in these reports, the presence of the vasoconstrictor drugs gives additive prolonging effects. The preparations without vasoconstrictors are indicated in patients with intra-arterial clotting particularly when dealing with coronary artery thrombosis.

HEPARIN / PITKIN MENSTRUUM FORMULAS

	With Vasoconstrictors		Without Vasoconstrictors	
Heparin, sodium salt, mg	3000	2000	3000	2000
Epinephrine hydrochloride, mg	10	10	0	0
Ephedrine sulfate, mg	250	250	0	0
Chlorobutonol, mg	05	05	05	05
Eucupin dihydrochloride, mg	10	10	10	10
Pitkin menstruum, cc	30	20	30	20

TABLE I

Heparin/Pitkin Menstruum formulas

In all patients it is essential to achieve prompt and maximum anticoagulation responses; therefore, the initial dose of heparin in the Pitkin Menstruum should be 400 mg. administered as a deep subcutaneous injection, preferably in the anterior or lateral aspect of the thigh. About 90% of subjects are normal reactors, the remaining 10% being either hypo- or hyper-reactors and requiring greater or lesser dosages respectively.

All coagulation time determinations are estimated by a modified Lee-White-Howell method[2, 9]. Compared with a normal coagulation time of 9-15 minutes, a coagulogram of 30-60 minutes is considered an adequate "heparin effect". Prolongation of coagulation time after each individual deposit endures for 48 hours or more as indicated in *Fig. 2*. It is comforting to know that the administration of larger dosages of heparin/Pitkin Menstruum to insure satisfactory responses does not invite the hazard of excessive amounts of dicumarol.

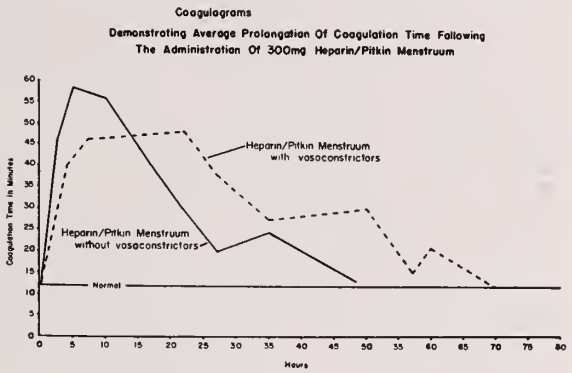


FIGURE 2

Coagulograms demonstrating average prolongation of coagulation times following the administration of 300 mg. heparin/Pitkin Menstruum

After the format of response has been ascertained, subsequent injections can more or less be routinized. For the normal reactor a conventional dose of 300 mg. given every other day during the early acute thrombotic phase will suffice to prevent propagation and promote resolution of the thrombus. This schedule must be maintained for 3 to 4 implants to accomplish uninterrupted, effective heparinization. Thereafter, if justified by the coagulation time responses, the individual dose may be given at 3 to 4 day intervals and the amount of the drug reduced as dictated by the specific case. In all instances, the span of treatment must be continued until the patient is permitted out of bed and if fully ambulatory.

REACTIONS, COMPLICATIONS IN THE USE OF HEPARIN/PITKIN MENSTRUUM: THEIR TREATMENT — 1. The objection to the earlier experimental preparations, especially the pain factor so disturbing to the patient, has now been controlled by careful buffering so that the pH of the gel is more physiologically acceptable and the tendency to precipitation noted in the original ampuls is overcome. Other side-effects of the heparin/Pitkin Menstruum prepara-

continued on next page

*Prepared and distributed by William R. Warner & Co., Inc., New York.

tion are trivial[2-5,7,9]. On rare occasions some oozing will occur from the needle puncture. In the several thousand deposits that have been made there was but one instance of hematoma of sufficient proportion to justify interruption of heparinization in a patient with post-partum thrombophlebitis. The patient made an uneventful recovery.

2. Following the administration of ampuls containing the vasoconstrictor drugs, the patient will occasionally complain of palpitation and nervousness. These reactions require no treatment and disappear within a short time.

3. Digitalis is said to inhibit the anticoagulant action of heparin. If possible, avoid the use of this drug during period of heparinization.

4. If suspension of heparin activity is desired, small transfusions of whole blood or relatively fresh bank blood will inactivate any circulating heparin. An ice bag to the site of deposit or a tourniquet above it, will suspend or slow up the absorption of the drug. In our experience the use of protamine for abrupt interruption of heparinization has not been necessary.

5. In hypertensive patients or those with myocardial disease, it is preferable although not mandatory to use heparin without vasoconstrictor drugs in order to avoid the transitory subjective vasoconstrictor effects.

SUGGESTIONS FOR TREATMENT—1. In cases of thrombophlebitis, it is advisable to inject the heparin into the thigh which is normal. Avoid using the affected thigh for deposition of heparin until the swelling has partially receded.

2. For hyper-reactors employ the 2 c.c. ampul which contains 200 mg. of heparin sodium salt. For hypo-reactors continue to administer 400 mg. This is accomplished by combining two 2 c.c. ampuls each containing 200 mg. of heparin sodium salt. Where vasoconstrictors are indicated use only one ampul with vasoconstrictors in the combination inasmuch as the amount of vasoconstrictor drugs contained in the one ampul will suffice for the entire dose of heparin.

3. For effective heparinization the blood coagulation time should be not less than three times the control coagulation time, i.e., 30-60 minutes as contrasted with a control time of 9-15 minutes.

Clinical Diagnosis

For optimum results heparin therapy should be inaugurated as early as possible. The advantages of preventing spread of thrombosis before it can give rise to pulmonary embolism or serious local damage are obvious and has been stressed repeatedly in the literature[24]. Admittedly, thromboembolism may be a treacherous and unpredictable condition; at times it occurs catastrophically and without warning. Nevertheless, if one is alert for slight premonitory signs, these will be discovered more often than has been supposed. One such diagnostic sign described by Allen[25], is an inexplicable rise in the pulse, temperature and respiration at the same reading or observation. Where, after operation, these have shown the normal downward course, any fresh rise, however small, after the fourth or fifth day, must always evoke suspicion. This applies equally to the puerperal woman, and to cases of fracture. Another sign sometimes observed is an unaccountable feeling of disquietude and restlessness which affects the patient. Or he may state, perhaps not until questioned, that he was kept awake during the night by a faint ache and a feeling of cramp in one of the calves, so-called "charley horse", a symptom which may already have disappeared. Complaint of even a slight stitch or pain in the chest must arouse strong suspicion of pulmonary infarction which is confirmed if the patient develops an irritative cough or expectorates blood-streaked sputum. It may be assumed that the majority of so-called "lung complications" observed post-operatively or post-partum, and in aged people confined to bed for reasons other than general debility, are due to pulmonary infarcts secondary to thrombosis somewhere in the peripheral parts of the body.

If any of these general signs are noted, a detailed physical examination must be made to elicit the cause. Examination consists of palpation of the groins, inner aspect of the thighs, popliteal spaces, the calves and the veins of the feet looking for swelling and tender areas. Conspicuous signs need not necessarily be present. In early cases one may note only slight swelling of the lower leg, an increased glossiness and tension of the skin, a faintly cyanotic discoloration in comparison with the other leg, and prominence of the superfiicial veins of one leg as compared with the other. All these signs need not necessarily be present but, if one or more of them is observed, the probability of an incipent thrombosis is considerably increased.

The most important sign is direct tenderness in the calf, discovered by pressure with the palpating fingers. Such tenderness will be more significant if none is elicited when the muscles of the same level are compressed from side to side. An increase in the consistence of the muscular part of the calf is another customary feature of thrombosis. Finally, the foot is brought into dorsal flexion and, if pain is induced (Homans sign) it is very significant of deep venous thrombosis.

PHLEBOGRAPHY—The clinical importance of phlebography of the lower extremities is still unsettled. It seemed to us that the latter could be more clearly defined as an aid to the evaluation of the procedure. In a study by Epstein, Wasch and

Loewe[26], apparently normal individuals were subjected to phlebography of the lower extremities, as a result of which the following conclusions seemed warranted. Within its limitations phlebography may provide information as to the patency of the superficial and deep venous circulation. The normal variations which may be observed in phlebograms of the leg make it hazardous to venture a diagnosis in the absence of very striking changes. There is a marked variation in the appearance of the deep leg veins which makes it extremely difficult to reach a trustworthy opinion as to the presence of intrinsic thrombotic changes in those areas. The appearance of the popliteal and femoral vein is more constant, but here too, normal variations occur which may confuse the unwary into venturing a diagnosis of thrombotic changes. Because of the difficulty of establishing the normal standard we have abandoned the routine clinical use of phlebography.

Analysis of Results and Clinical Observations

The clinical deportment of heparin/Pitkin Menstruum has been observed in 251 patients representing all forms of venous thromboembolic disease (*Table II*). The final judgment in any treatment program for thromboembolic disease is predicated on the statistics with respect of pulmonary embolization. It is noteworthy that of the 251 cases, 95 had from one to six pulmonary embolizations prior to initiating subcutaneous heparin therapy. There were five fatalities in this series of 251 patients (1.9%). Four of the fatalities came early in our experience and served as an object lesson for standardizing and formulating our present program of therapy and dosage schedules.

HEPARIN/PITKIN MENSTRUUM IN THE TREATMENT OF 251 CONSECUTIVE PATIENTS WITH VENOUS THROMBOEMBOLIC DISEASE

Classification	No. of Patients	No. of Patients with Pulmonary Embolization	Deaths Due to Pulmonary Embolization
Post-operative Thrombophlebitis and/or Phlebothrombosis	102	45	3
Thrombophlebitis and/or Phlebothrombosis, Miscellaneous *	92	38	1
Post-partum Thrombophlebitis	30	7	0
Post-infectious Thrombophlebitis	10	0	0
Post-traumatic Thrombophlebitis	8	5	1
Migrating Thrombophlebitis	9	0	0
Totals	251	95	5 (1.9%)**

* Occurring without ascertainable exciting cause (thrombophiles), or as a complication of carcinoma, varicose veins, etc.

** 4 of the 5 treatment failures occurred before the optimum treatment program was established

TABLE II

Heparin/Pitkin Menstruum in the treatment of 251 consecutive patients with venous thromboembolic disease.

The fifth treatment failure occurred in a 63 year old, obese, white woman who had, at the outset, an obscure clinical syndrome which ultimately proved to be bilateral massive thrombophlebitis with repeated extensive pulmonary embolic episodes. The clinical diagnosis was at no time characteristic and even after the thrombotic involvement of peripheral veins was evidenced, it was felt that the clinical picture was secondary to an underlying malignancy. Heparin/Pitkin Menstruum therapy was inaugurated more than three weeks after the known onset of the condition. A standard dosage schedule was administered, the patient receiving 300 mg. of heparin/Pitkin Menstruum subcutaneously every other day for five injections with seemingly satisfactory anticoagulation responses. Despite this the patient went into deep shock as a result of a massive lethal pulmonary embolus. At necropsy the deep veins of both lower extremities were found to be completely occluded with massive thromboses extending up to and involving both femorals, iliacs, the inferior vena cava, ovarian veins and renal veins. The extent of the thrombotic lesion, which was never suspected clinically, evidently made the patient refractory to the average dosages of heparin. Our experience leads us to believe that there is a parallelism between thrombus mass and heparin requirements. Had the extent of the lesion been recognized and the dosages intensified further thrombus formation might perhaps have been prevented. It seems hardly likely that the patient would have survived high vena cava ligation, nor is it possible to assume that further embolization would have been obviated. As a result of the experience in this case the following program has been formulated. Once a diagnosis of thrombophlebitis or venous thrombembolism has been entertained in an individual who has been ill for some time, it must be assumed that the condition has, from the very outset, been one of intravascular thrombosis and a greatly intensified dosage schedule must be instituted. Such a dosage schedule might well be 400 to 500 mg. every other day or even daily in order to maintain coagulation times between 1 and 2 hours. This compares with a coagulogram of 30-60 minutes obtained with conventional dosages of 300 mg. every other day which is adequate for the average case. It may well be that patients with massive wide-spread thromboses can be salvaged only in this manner if at all. It is timely to stress again the importance of early diagnosis in order to obtain optimum results.

As an offset to these treatment failures mention may be made of 7 patients with multiple pulmonary emboli despite vein ligation with complete recovery following use of the subcutaneous heparin preparation.

Particularly significant and informative are the 22 patients who were successfully treated with heparin in the Pitkin Menstruum following single or multiple massive pulmonary embolizations without any manifestation of peripheral vein involvement; these patients could not conceivably be subjects for proximal vein ligation. Finally, it is

continued on next page

worthy of comment that in 7 patients subcutaneous heparin was successfully employed following failure with dicumarol.

In uncomplicated phlebothrombosis, heparinization need be continued only for 7-10 days, while cases complicated by pulmonary infarction, either single or multiple, require an additional 7-10 days of heparinization. The full heparin effect must be present when the patient is fully ambulatory. This conservative span of treatment is postulated not only on clinical experiences but also as a result of experimental work indicating the span of time needed to get restoration of the vascular stream and the importance of giving sufficient treatment to allow and promote collateralization and development of the tributary vein system.

It is evident from a critical review of our series of patients that a comprehensive trial of subcutaneous heparin in the Pitkin Menstruum has been carried out with good results. While other expedients, such as sulfonamides and penicillin may be used in conjunction with it, heparin alone in clinically established thrombophlebitis irrespective of etiology is attended with consistent, beneficial, if not dramatic results. These include diminution of temperature, pain and swelling which often become manifest within a few hours after initiation of therapy. This improvement is predicated on the limitation in the progress of the formed thrombus, while the original inflammation expends itself and the thrombus either resolves or becomes organized. Since there is no further actual propagation of thrombus there is a rapid and marked diminution in vasospasm. In all cases, morbidity is lessened and convalescence accelerated. It is felt that prolonged, deforming and incapacitating edemas are further prevented in these patients by keeping lymphatics patent.

Coincident with the institution of heparin therapy the liberal use of papaverine is recommended, 1 to 3 grains every four hours intramuscularly or even intravenously and, later, maintenance dosages by mouth. Smoking is strictly prohibited. Paravertebral block, although used extensively in arterial occlusions is not used by us in thrombophlebitis as a routine measure since we have found that venous spasm disappears promptly following administration of subcutaneous heparin.

As has been described earlier, the general systemic anticoagulation effect of heparin seems to us to be a more rational therapeutic weapon than local vein ligation especially when the precipitating cause of thrombosis is not yet known and the initiating site of thrombosis can be ascertained in many cases only by vague and indeterminate clinical signs. The ready availability of immediate adequate and rational conservative treatment without moving the patient has caused vein ligation to be supplanted by the subcutaneous heparin therapy in our Clinic.

Inasmuch as our observations with the heparin/-Pitkin Menstruum preparation have been more elaborate in venous thromboembolism this aspect of thromboembolic disease has been presented in greater detail. Limitation of space obviates similar consideration of all our current studies in various arterial thrombotic disorders. However, exploratory investigations in the treatment of coronary artery thromboses are so significant and promising as to justify brief comment.

Coronary artery thrombosis in particular offers a very fertile field for anticoagulation therapy. In coronary artery thrombosis there is a triphasic therapeutic attack. First, and most important perhaps, is to prevent propagation of the thrombus from what, in many instances, is merely an occlusive involvement of small twigs of the coronary vessels. In this manner it is hoped to limit the degree of myocardial infarction and consequent myocardial damage. All too often the propagation thrombus is the lethal factor. The second treatment approach is prevention of embolization from mural thrombi secondary to the myocardial infarction. The third phase of the treatment is leveled at the not infrequent thrombotic involvement of deep venous channels resulting from slowing of the vascular stream in the bed-ridden convalescent patient. The, at times, ominous resultant pulmonary embolization may be clinically confusing and erroneously attributed to cardiac factors. Dicumarol is admittedly useful only in the second and third phases of therapy and is not helpful, because of its delayed action, in the initial phase of thrombus propagation. Heparin/Pitkin Menstruum, because of its prompt action and simplicity of subcutaneous administration, would seem to be the anticoagulant of choice, particularly in the initial and important aspect of coronary thrombosis. For optimum effects the immediate administration of anticoagulation therapy is essential. The results in a consecutive series of 20 patients with severe acute coronary thrombosis, electrocardiographically confirmed, have thus far been most encouraging.

Summary and Conclusions

1. More than 450 patients with various forms of thromboembolic disease have been treated with heparin/Pitkin Menstruum. This series included 251 consecutive patients with venous thromboembolic disease.

2. The treatment of venous thromboembolic disease with subcutaneous heparin in the Pitkin Menstruum was attended with lessened morbidity, prompt and rapid clinical improvement, and little or no residual edema. The causative factors re-

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THE GERMAN MEDICAL WAR CRIMES*

— Their Nature and Significance —

CORTEZ F. ENLOE, JR., M.D.

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I AM particularly pleased to be here this evening and to speak to you about some of our experiences in dealing with the Nazi war crimes of a medical nature. Viewed from any perspective this is a subject replete with distaste and revulsion. Yet it is important to us as physicians to be aware of the situation for these Nazi physicians have raised a specter that no group of medical men may ignore. The revelations of Nuremberg impose upon us a deep obligation to all people to show why and how these things happened. In the words of the prosecutor at Nuremberg, "It is incumbent upon us to set forth with conspicuous clarity the ideas and motives which moved these defendants to treat their fellow men as less than beasts. The perverse thoughts and distorted concepts which brought about these savageries are not dead."

By understanding the evil work of these medical war criminals, we can demonstrate what happens when the Hippocratic Oath is violated. There is no record of such a calculated attack on the principles of medical ethics as that launched by the Nazi physicians. There is not one rule of conduct they failed to violate. Yet we as physicians may learn by contrast with their transgressions the true value, the strength and the purpose of the ethical principles guiding our profession.

The Crimes

One or more of the twenty-three medical defendants have been found guilty of criminal behavior in connection with the following specific experiments:

1. Cold water immersion, with periodic blood tests and different methods of resuscitation.
2. Blood transfusion.
3. Effects of vaccine and pressure changes.
4. Sterilization—chemical, operative, and radiological—with controls by artificial insemination.
5. Liver puncture.
6. Excision of parts of the body.
7. Experimental operative surgery—non-indicated operations—for instructional purposes.
8. Exposure to gas and chemicals for varying periods and results checked by autopsy.
9. Euthanasia.
10. Deliberate septic infection.

It is not necessary to dwell at length upon all of these "investigations" (they can hardly be dignified by that name). They are not instructional from a scientific point of view for little or nothing was learned from them. It is sufficient, therefore, to mention only those which will provide an insight into concentration camp medicine.

The cold water experiments have been the subject of exhaustive study by Allied medical intelligence. Thus the records are complete.

These experiments were conducted largely at Dachau Concentration Camp outside Munich. Their purpose was to devise a means for rapid and complete resuscitation for Luftwaffe fliers downed in the North Sea. To simulate such conditions they immersed non-volunteer inmates in tanks of water cooled to varying temperatures for different periods of time. Electrodes were placed in the various orifices of the body and all objective manifestations of bodily activity were carefully noted. Our records show that some subjects were still alive after exposure to 40°F. for fourteen hours.

Almost every conceivable method of resucitation was attempted. One salacious method conceived by Dr. S. Rascher and his colleagues was that of placing the chilled and unconscious victim in bed between two nude gypsy girls.

A conservative estimate given by two inmates who were forced to aid in such work holds that 350 men and women failed to survive the experiments. Yet what purpose was served? Rascher was put to death (it is believed) by the SS shortly before the American troops took Dachau. The official report on his work concludes that he and his wife, Nini, who was Himmler's mistress for a brief time, waded in blood and obscenity only to prove what the Russian scientist, Laptschinski, had suggested in 1880; namely, that rapid and intense re-warming is the most effective means of resuscitating the person exposed to cold.

continued on next page

* Presented before the Providence Medical Association at Providence, October 6, 1947.

Another group of experiments performed for the Luftwaffe on Himmler's prodding studied the effects of sudden pressure changes on the body. We did the same work in the Air Forces at Randolph Field. The Navy conducted similar research at Bethesda, Maryland. There was, however, one important difference—what we did on animals the Nazis did with human beings.

At Dachau, prisoners were placed in a hi-altitude decompression chamber at simulated ground level. They were then shot to levels simulating atmosphere at thirty, forty, fifty and even sixty thousand feet. Then, too, the reverse procedure was tried. At death, which usually followed, the subjects were autopsied and the brain was examined for aero-emboli.

I should like to read to you from one document. I'll spare you any more.

"The third experiment of this type took such an extraordinary course that I called an SS physician of the camp as witness, since I had worked on these experiments all by myself. It was a continuous experiment without oxygen at a height of 12 km conducted on a 37 year old Jew in good general condition. Breathing continued up to 30 minutes. After 4 minutes the experimental subject began to perspire and to wiggle his head, after 5 minutes cramps occurred, between 6 and 10 minutes breathing increased in speed and the experimental subject became unconscious; from 11 to 30 minutes breathing slowed down to three breaths per minute, finally stopping altogether.

"Severest cyanosis developed in between and foam appeared at the mouth.

"At five minute intervals electrocardiograms from 3 leads were written. After breathing had stopped Ekg was continuously written until the action of the heart had come to a complete standstill. About ½ hour after breathing had stopped, dissection was started."

Far more was learned in this country on this important aeromedical problem than were learned by all these experiments. Furthermore, human subjects were asked to volunteer and were used but exposed only to the limits of predictable safety.

To those to whom war is an endless procession of people filling out forms to satisfy the insatiable appetite of bureaucracy, a non-experimental medical crime will have particular fascination. It is the crime of mass sterilization.

In 1943, Himmler and his colleagues were faced with the problem of killing off a large number of concentration camp inmates. Yet, since most of these hapless individuals could do productive labor in the adjoining prison factories, the problem resolved itself into one of preventing such "subhumans", as they were called, from reproducing their kind. Furthermore, as was freely noted in records in our hands, if such a group could be quietly and secretly sterilized, the process could be applied to the population of enemy countries at large.

One resulting procedure consisted in having the people to be sterilized file into a room disguised as an office. On a high counter in the room, before which the victims stood, were placed lengthy questionnaires which had to be filled out. While they were standing there filling out the forms they were exposed, without their knowledge of course, to a castration dose of x-ray. These statements are substantiated by former inmates who exhibited x-ray burns in the region of the groin, some fresh, others healed.

A second mass sterilization method was attempted which consisted in putting the dried juice of an obscure plant in the flour fed to a section of the population. The dehydrated juice was supposed to sterilize both men and women—particularly the latter.

A third attempt consisted in surreptitious injection of a scarifying liquid into the uterus during what was supposed to be a routine examination. The records suggest that the liquid was silver nitrate.

The experimental surgery was likewise ill-conceived and proved nothing. It was novel only in its brutality and is useful to us only as an accurate measure of the depth to which these physicians sank in their degradation of humankind.

Generally, experiments conducted on the female prisoners at Ravensbruck Concentration Camp concerned bone, muscle, and nerve regeneration, bone transplantation and experiments with sulfanilamide and other drugs. Fisher and the woman physician, Oberhauser, were in charge of this work which had the over-all direction of Doctor Gebhardt, Himmler's physician.

The experiments varied. In one set incisions were made in the legs to simulate battle infections. Such wounds were infected artificially. Sometimes fractures were induced. Only after several days would therapy with untried drugs be instituted. In another group bullet wounds were initiated and particularly virulent strains of Clostridium welchii introduced. In each of these experiments controls were maintained by treating some cases and permitting the others to remain untreated.

That men trained in medicine, who had engaged in practice as reputable physicians, could participate in such worthless operations of such bestiality is almost inconceivable. Yet and on the other hand, very little was inconceivable under the Nazis.

Bone transplantation was attempted on non-volunteers. The record shows one instance where Gebhardt had the scapula removed from one patient and taken to a distant hospital where a foolish

attempt was made to transplant it in another patient.

The German health officials were fairly well-informed of the activities in medical research in the United States during the war. In fact, when we broke into the files of their office of Medical Research and Development, the first paper in the documents on antimalarials was an article by Paul DeKruif that had appeared in the Reader's Digest. Another scientific article in the lay press caught Himmler's eye and set off another series of criminal medical experiments.

In 1944 a copy of *Life* Magazine came across the Gestapo leader's desk. In it was a description of the desalting experiments which Doctor Andrew Ivy of Chicago and others were conducting for the Navy. Forthwith, seawater experiments were begun at Dachau. One of the stated purposes, said Himmler, was to prove to Hitler that German SS scientists were superior to the Americans. Countless inmates died in these experiments.

The medical war crimes involving searches for cures of disease affecting the German Armed Forces made the closest approach to usefulness. However the most that can be said for these endeavors—and it is a great deal when they are measured alongside what has been previously described—is that they contained a faint trace of scientific method and reason.

In the experiments with diseases several well-known physicians used the inmates to investigate the value of various vaccines—mainly typhus, and to develop their new theory of the treatment of malaria.

The general pattern of the typhus experiments was as follows. A group of concentration camp inmates selected from the healthier ones who had some resistance to disease were injected with the typhus vaccine which was to be tested. Thereafter all the persons involved in the experiments were infected with virulent strains of the organism. This included other inmates who had not been vaccinated and who were to be used as controls. It also included a third group, this latter group being infected for the sole purpose of keeping the typhus virus alive and readily available in the blood stream of the inmates. Approximately 121 people died in these experiments. They were run by a Doctor Ding, who later committed suicide, and were under the supervision of the Chief of the German Public Health, Doctor Leonardi Conti.

Many of the records of the typhus investigation were carefully preserved and were captured. They revealed what may be called the only contribution to medical knowledge afforded by concentration camp medicine, for if these records are accurate, and therein lies the question, the Nazis did succeed in establishing the incubation period for typhus and in developing a non-virulent strain of this virus. This matter is being further investigated at the present time. Yet it must be said that the results reported were influenced so greatly by the desire on the part of the investigators to please their superiors, and the work itself was conducted in such a milieu of chicanery, that the reliability of of any information must be tested with a great deal of circumspection.

The malaria experiments were conducted by Doctor Klauss Schilling who, in his day, was one of the most outstanding parasitologists in Europe. Indeed, the International Congress of Parasitology in the early part of this century honored him by dedicating a large volume of the works of its members to Schilling. However, when he was interrogated he was a wan, broken old man exhibiting every sign of senility—a pathetic character who pleaded for hours that his work at the Dachau Concentration was done only as his last service to humanity. He was hanged on May 25, 1946.

Schilling was working in the Pontine Marshes of Italy on a huge malaria experiment when he was called by Himmler in 1942 to go to Dachau to set up a model investigation of malaria. He spent three years there in testing what he called his theory of immunity to malaria. He injected tertian malaria into a group of selected individuals, permitted the crisis to occur, and then proceeded to allay the crisis with atabrine. According to his story, at the end of the third bout of fever he attempted to render the patient asymptomatic with huge doses of pyramidon. By so doing he hoped to render the protozoa avirulent and develop in the individual a relative immunity to the disease.

The criminality of such experimentation lies in the fact that not only has such work been done on animals and proved wholly unsuccessful, but also that as a malariologist he was well aware of the fact that many of his subjects would die, as indeed they did. According to the findings of the Court, malaria was the direct cause of 30 deaths with 300 to 400 persons dying as the result of secondary complications.

Schilling's reaction in the early interrogations were indicative of the thinking of this group. He was asked about the volunteer aspect of his work and asked if that did not violate one of the cardinal principles of medical ethics. Was he not aware, he was asked, that he was committing murder? His reply took us off balance. He said, "Why should you criticize me? Look what you are doing in Joliet (the Federal penitentiary at Joliet, Illinois, where malaria experiments were done on volunteer inmates. The results of this work were published in *Life* Magazine during the war). We replied that the safety of the work had been clearly demonstrated in animals, that every precaution was

continued on next page

taken to safeguard the life of the individual concerned, and that not one had suffered any consequences as the result of the experiments. Furthermore, these men were volunteers. With the typical Nazi regard for those who must be incarcerated he replied ,"Who can volunteer in prison?"

These in sum, are examples of the nature of the medical war crimes perpetrated by the Nazis. Other experiments involving mustard gas, wounds with poison bullets, and those in which the most effective methods for committing suicide were explored* were conducted but their recitation here does not contribute to a further understanding of the nature and implications of these crimes.

It is apparent that only a few of the many thousands of physicians in Germany participated in these medical war crimes. The record shows that in all there were about 70. It is surprising that there were not many more. This can only be explained by the fact that these experiments appear to have been undertaken primarily to satisfy a political, not a medical motive.

These experiments were the work of the SS which was Himmler's, or more accurately, the Nazi party's private police army. The men were admitted to this organization as volunteers and only those were accepted who were true believers in the tenets of national socialism.

It is in the nature of a dictatorship that those subordinate to the Dictator soon began to develop their little private empires and to use these for greater accomplishments to win the favor of the Dictator; furthermore, to fortify their position against the day when the Dictator might die. The SS was Himmler's empire. Very early in the war he became envious of the accomplishments of the Army and the Air Force, and even of the German Public Health Service, and he was determined to demonstrate to Hitler that his doctors could also contribute to the advancement of medical knowledge and furtherance of the German war effort. Fortunately for us, Himmler kept most careful and complete records of all of his operations. If history sets him down as one of the worst of barbarians, he has only his penchant for paper work to blame.

With but one or two exceptions, all of the men in this work belonged to the SS and therefore were beholden to Himmler. Some of them had been real scientists, but by and large, most of them were of the same low calibre of Doctor S. Rascher whose freezing experiments at Dachau have been previously described. When the rewards of political favor are so high as they were in Germany, and the calibre of the men so low as that of the concentration camp physicians, it is not surprising that experiments such as have just been described were the result.

Interrogations on their capture and the testimony at Nuremberg reveals that the minds of these men were utterly closed to the Hippocratic concepts of medical ethics. Like the most ardent of Nazis, they believed that when the individual becomes useless to the state, he is without human rights and may be used in any way that will benefit the state. With this belief, it was easy for these men to use human beings with even less regard than we use animals. The lesser tragedy is that they accomplished nothing.

The German medical profession as a whole is not to be blamed for the excesses perpetrated in this human experimentation. In interrogating hundreds of physicians and nurses of every type throughout Germany, we found only a few who had any knowledge of what was going on. It paid a man not to know. Also, it is doubtful if anything could have been done to stop it.

In October 1942, Doctor S. Rascher made a report to a group of scientists in a medical meeting in Munich in which he revealed that his experiments had been done on human beings picked at Dachau. To this revelation there was a good deal of grumbling, a reaction which became more pronounced when Rascher sneered, "You think you are human physiologists, but all you ever do is work on guinea pigs and mice. I am the only one who does and knows human physiology because I experiment on humans."

When he returned to Dachau, Rascher described this mild opposition in a letter to Himmler. The Gestapo chief, having once been a school teacher who considered himself a scientist, took an avid and personal interest in the criminal experiments. His reaction to the profession's opposition was enough to silence anyone who lived in Germany under the Nazis. He wrote to Rascher in October 1942, "People in Christian medical circles who today still disapprove of the experiments on human beings, but prefer to let brave German soldiers die from the consequence of intense cold, are to me nothing but traitors to our country and I shall not hesitate to supply the names of these people to the authorities who are in a position to take action against them."

Doctor Andrew C. Ivy, who served as the scientific representative of the United States Government at these trials and who was cross-examined by the witnesses themselves at Nuremberg, has contributed greatly to our understanding of this problem. He and I now find ourselves in agreement that one may conclude from these experiments that they demonstrate how political considerations, how an ideology such as that of totalitarian-

* The methods of suicide of a number of Nazi leaders, including Eva Braun, Goebbels and his family and Goering, had been carefully worked out and tested for their efficacy on the inmates of concentration camps.

ism can capture and lead a profession which has such high ideals and virtually subvert that profession, or some of the members of it, into performing atrocities.

The ideology which made these crimes palatable to German physicians arose from the materialistic concept that man is purely a rational animal. That being so, his welfare and happiness are the result of reason and not the result of the sanctity and dignity of the person and not to be confused with morality. If all knowledge were science the Nazi doctors would not have been tried and convicted, but they overlooked, and this is their crime in Christian eyes, that man is only partially rational. He is also religious, moral, esthetic and social. As Karl Brandt has said, since man has value only so long as he is a rational animal and contributing to the state, there is no crime in using the body of one languishing in prison for the good of these who make up the "acceptable" society on the outside.

For we who must every day carefully observe the limitations of the Hippocratic code of ethics, these crimes carry a violent and commanding lesson. It is a lesson which must be understood if the medical code of ethics, and the respect which it engenders on the part of the layman, is to survive. We must understand that science cannot become an instrument of the state, nor can the desire for gain in medical knowledge be pursued beyond the pale of medical ethics.

There is a broader aspect to these crimes committed in the name of medicine. At a time when the general nature of science and its relation to man is being so closely examined, twenty-three German scientists have been tried for medical crimes and sixteen of them have been found guilty. Some are to be punished by death. Others have received long prison sentences. Here was cruelty without moral restraint, scientific endeavor without the limitation of ethics. Here were German physicians demonstrating Nazi doctrine at its worst. Here is what happens when the desire for scientific achievement runs amuck and is without regard for the dignity of man.

ANTICOAGULATION THERAPY IN THROMBOEMBOLIC DISEASE

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sponsible for the five treatment failures have been analyzed. Treatment failures with other methods have subsequently ended in recovery following the routine administration of the heparin/Pitkin Menstruum preparation.

3. Exploratory studies in the field of prophylaxis and in the treatment of various arterial thrombotic disorders, including coronary artery thrombosis and peripheral vascular diseases are sufficiently promising to justify further intensive investigations.

4. As a result of observations of its clinical deportment in over 450 patients with thromboembolic disease, the subcutaneous administration of heparin in the Pitkin Menstruum is recommended as a safe, simple, practical and effective method for anticoagulation therapy of intravascular thrombosis.

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MOLLUSCUM CONTAGIOSUM TREATED WITH SULFADIAZINE

BENCEL L. SCHIFF, M.D.

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SOMERVILLE,[1] in 1941, reported a cure of molluscum contagiosum by the oral administration of sulfapyridine. Until that time, reports were rare on the successful treatment of virus diseases with the sulfonamide compounds. In 1942, Hill and Downing[2] presented a case with clinical cure of molluscum contagiosum by oral use of sulfapyridine.

Motivated by these reports and by the simplicity of this treatment as compared with the usual methods of desiccation or extraction and curettage, which would be time-consuming and tedious in an extensive case in a child, the writer employed oral sulfadiazine therapy in a patient with generalized molluscum contagiosum. A complete involution of the lesions was obtained.

Described first by Bateman[3] in 1817, molluscum contagiosum is an infectious disease, caused by a virus, and limited to the skin. Lesions, when fully developed, have a characteristic appearance. They are round, sharply circumscribed, firm papules, elevated, of semi-globular shape. Their color is that of wax, with a pearly sheen, and they are umbilicated. When squeezed, a mass is extruded in form of a plug, the so-called molluscum body.

Incubation period varies, being a matter of weeks. Most commonly involved sites are the face, the upper thorax, the arms, the genitalia and the inner surface of the thighs, although no region is exempted. Subjective symptoms seldom occur. However, there may be mild itching, and, at times severe itching. Since the disorder is auto-inoculable, the resulting scratching tends to spread the eruption, and secondary infection may result. It is not unusual to see abscess formation.

The infection occurs most frequently in children and young adults. Epidemics have been reported among inmates of children's homes, in schools, turkish baths and swimming pools. Immediate and mediate contact may cause transmission of the disease. Immediate contact is most frequently provided by athletic activities, although infection is not uncommonly acquired on the occasion of sexual intercourse. Mediate contact is often provided by towels, bathing suits and athletic apparel.

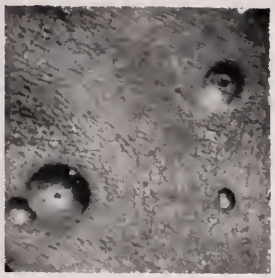
Although the characteristic appearance of the lesion is suggestive, definite diagnosis can be made only by removal of the molluscum body, and by identification of the molluscum cell in potassium hydroxide preparation, or by biopsy. The microscopic examination shows a picture so typical, that diagnosis can scarcely be missed.

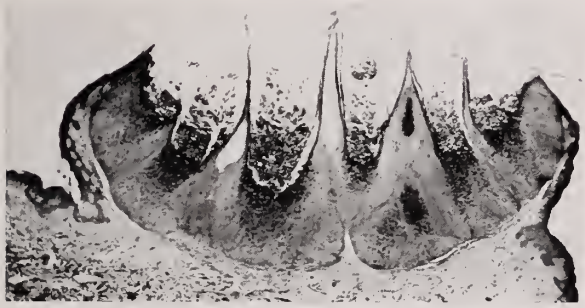
Case Report

"E. D., a white boy, aged 6, was examined on May 26, 1947. He had been sent home from school because of a bizarre eruption on his body Examination revealed approximately 300 globular, translucent papules, centrally umbilicated, from 5 mm. to 1 cm. in size. Lesions appeared on the trunk, abdomen, and a few were noted on the arms and neck. Some were secondarily infected. The expressed content of one of the lesions was treated with potassium hydroxide, and showed molluscum bodies.



Thorax and abdomen of a six-year-old boy, with about 300 lesions of molluscum contagiosum.





Molluscum contagiosum
Typical clinical and low-power pathological features of one entire lesion. (*Courtesy of Dr. F. Ronchese*)

The mother was instructed to give the child 1 tablet, 0.5 gm., of sulfadiazine, three times daily for ten days. The child returned for re-check at the expiration of the ten day period, and examination showed shrinkage of lesions. No new lesions were seen. Since there was no incidence of side-reactions to the drug, the same therapy was continued for another ten days. The child was re-examined at the end of the second ten-day period, and at that time 75 per cent of the lesions were involuted. The same treatment was continued for an additional ten days.

Thirty days after treatment had been instituted, there was complete disappearance of all lesions, except for residual pigmentation. Since the incubation period varies, the patient was advised to report back on August 28, 1947, and on that date showed no trace of his previous dermatosis. The case was considered clinically cured.

Total amount of sulfadiazine received by the patient was 15 grams. No sulfadiazine blood level was determined."

Comment

A case of extensive molluscum contagiosum, a virus disease, which responded successfully to oral sulfadiazine therapy, is presented. When there is no medical counter-indication to the use of this drug, it is considered the choice treatment, especially in young children, since they are uncooperative and sensitive to the older and painful destructive methods. Of course, no internal treatment is indicated, when only a few lesions are present.

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RESTAURANT SANITATION

CLEANLINESS is next to Godliness. This classic phrase is not alone applicable to purity of thought and soul. It has a material implication which could well be inscribed in the minds of our restaurateurs.

It is obvious to those who are observant and interested that many eating places do not live up to the common laws of decency in their relations with the community. From a health view-point the unsanitary practices in many eating and drinking establishments are the cause of an undetermined but apparently appreciable number of severe illnesses each year.

The Providence Medical Association through an appropriate committee has studied the problems presented by unsanitary procedures in restaurants and other eating and drinking establishments.

The committee in its summation has suggested that City Officials promulgate a new and more effective ordinance; employ more inspectors; and educate the food handlers and proprietors before licensure.

It is indeed astounding that owners and managers, and the restaurant organizations, are so lax as to evade deliberately the present laws and thus create a situation which requires more rigid laws and more frequent policing. The public must bear a share of blame for supporting obvious or suspicious unsanitary establishments.

It is somewhat of a paradox to find our civilization being proclaimed for its high attainments, but find a greater necessity for more and more laws which deal with simpler and basic principles. It is a travesty on success that supposedly intelligent and prosperous proprietors refuse to accept or follow decent principles of procedure. While such indifference exists new laws will be needed to prevent the unscrupulous from engaging in unethical practices.

The Providence Medical Association in proposing suggestions for improving conditions regrets that such action is necessary. It knows that in the last analysis the solution to the problem rests with the integrity of the person whose daily presence is needed to operate these establishments. It is hoped that the Restaurant Association and the city government will insist that he know and live up to the sensible standards proposed or leave this field, so vital to public health, to others who will.

CEREBRAL PALSY CENTER

More than a year ago an editorial in the RHODE ISLAND MEDICAL JOURNAL* commented on the development of interest within the State in providing facilities for children suffering from cerebral palsy. Since that time very definite progress has been made in developing this interest into something tangible.

*Rhode Island M. J. 29:595 (August) 1946

Early in 1947 a branch of the National Society for Crippled Children and Adults, Incorporated was established in Rhode Island and is known as "Crippled Children and Adults of Rhode Island, Incorporated." Under splendid leadership by its Board of Directors and Executive Secretary, this organization raised a substantial sum of money in the community through the sale of Easter seals and is now sponsoring a number of worth while projects in its own field. The organization has now made arrangements to sponsor a demonstration nursery school and treatment center for children with cerebral palsy. The school building at 24 Meeting Street has been loaned to the organization by the Providence School Department, and plans are now going ahead to provide equipment and staff for the project.

The objectives of this treatment training center are wide and sound. It is dedicated to help cerebral palsied children make the adjustment to normal living by guiding them toward optimal physical development and emotional security and through providing opportunities for social participation and intellectual stimulation. A second objective is announced as a program to help the parents of these patients through periods of observation, guidance, and education. Medical and allied research is considered another purpose of the Center, where it is hoped to evaluate present and devise new methods of training, medication, and diagnostic testing. It is hoped that out of this will come opportunities for the training of personnel, so that teachers and therapists may acquire experience that can be applied elsewhere in the State and possibly even in wider fields.

Support from various other community sponsoring agencies is being secured, and sources of funds for research are being approached. The medical consulting staff, composed mainly of members of the Rhode Island Medical Society, is being assembled, and an active medical and research staff has been appointed.

We are impressed with the developments which have been made within the past few months for better care for children with cerebral palsy and will watch with interest the growth of this Center for treatment, research, and training.

ROBERT N. NYE, M.D.

Dr. Robert Nason Nye, the Editor of the *New England Journal of Medicine*, recently died in Boston after a short illness. This Journal, one of the oldest in the country and easily one of the most outstanding has been led by Dr. Nye for ten years and during this period has certainly maintained the tremendously high standards of the past. An article, to make its columns, has had to pass a careful scrutiny to establish its worth and its editorials are fearless, pertinent and with delightful literary quality.

Dr. Nye was a many sided man. Besides doing his onerous work as editor he has been a pathologist, a holder of responsible positions in a public health laboratory and a professor of bacteriology and immunology at the Harvard Medical School; he has had many activities in research, the medical library, war work, the Massachusetts Medical Society, etc.

But, Dr. Nye was more than merely an able worker. He had a great zest for life. Although his short references to his sports would never bore those who did not share his hobbies, one sensed and vicariously enjoyed with him his fishing at Moosehead and his gunning on the marshes, shared with pleasant companions of his own calibre.

As his journal is the official publication of his state society, he has been accustomed to attend the yearly meetings of state editors and secretaries held by the American Medical Association in Chicago. The Editor and managing Editor of the Rhode Island Medical Journal when attending these meetings have made it a point to travel there with Dr. Nye and Dr. Michael Tighe, for many years secretary of the Massachusetts Medical Society. It is no reflection on the official meetings to say that these journeys out have been fully as valuable as anything we have got from the expeditions.

Intimate, frank discussions of our problems with these men have given us much we could never have got from formal talks and the good fellowship with these delightful characters will linger long in our memories.

Both men have died during the past year and our personal sorrow is genuine and profound.

COLLEGE OF PHYSICIANS MEETING

The American College of Physicians will conduct its 29th Annual Session at San Francisco, April 19-23, 1948. General Headquarters will be at the Civic Auditorium. Dr. William J. Kerr and Dr. Ernest H. Falconer, both of San Francisco, are the Co-Chairmen for local arrangements and the program of Clinics and Panel Discussions. The President of the College, Dr. Hugh J. Morgan, Professor of Medicine at Vanderbilt University School of Medicine, Nashville, Tennessee, is in charge of the program of Morning Lectures and afternoon General Sessions.

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SANITATION IN EATING ESTABLISHMENTS

(A Statement from the Providence Medical Association Through its Committee on Legislation)

THE PROVIDENCE MEDICAL ASSOCIATION has become increasingly concerned with the question of sanitation in eating establishments in the Greater Providence area. In contemplated action in the matter earlier this year, but was encouraged to believe the problem would be solved to some extent when the Rhode Island Restaurant Association announced in January that it planned to create a system of standards which would be stiffer than the minimum requirements of State and City sanitary regulations. However, that program, to our best knowledge has failed to materialize.

The Committee on Legislation of the Association has undertaken to evaluate legislation for the enforcement of effective sanitary procedures in eating establishments, and this Committee has offered its assistance to the special committee on Sanitary Investigation of the Providence City Council. This offer has been graciously accepted by the City Council Committee through its Chairman, Mr. Jerry Lorenzo.

The amount of illness that is due directly to the failure of eating establishments in the City to carry out effective sanitary procedures is not accurately known. Undoubtedly it is considerable. How widespread such contaminataion can be was cited by A. W. Fuchs, Sanitary Engineer Director of the United States Public Health Service, a year ago when he told the International Association of Milk Sanitarians that:

"Since 1923 the Public Health Service has compiled annual reports of milk-borne outbreaks of disease submitted by State Health Departments, and since 1938 these compilations have been extended to include outbreaks traced to water and other foods. During the seven-year period from 1938 to 1944 there was reported an annual average of 44 outbreaks from water, 41 from milk, and 212 from other foods. In other words, outbreaks traced to other foods have been nearly three times as numerous as those from water and milk combined. Another significant feature is the trend: Whereas outbreaks attributed to water declined during the war years and those from milk showed no significant change, a steady increase occurred in outbreaks and cases traced to other foods. *There is no doubt that the reported outbreaks and cases represent only a fraction of those actually occurring. . . .*

"Of the diseases involved in food-borne outbreaks, food poisoning and gastroenteritis are by far the most common. Thus, of 298 food-borne outbreaks reported for 1944, the diseases involved were: botulism, 9; chemical food poisoning, 8; dysentery, 7; food poisoning, 157; gastroenteritis, 94; trichinosis, 7; typhoid fever, 10; others, 6. Practically all of these diseases are controllable through appropriate sanitary measures, including refrigeration."

In fully appreciating the significance of the above statement it must be realized that each "outbreak" involves many persons, often several hundred.

The failure of some eating establishments to maintain stringent regulations of their own accord, the inadequacy of the present laws governing sanitary inspection, and the lack of trained inspectors to enforce the sanitary code effectively, prompts the Association, through its Committee on Legislation, to make the following recommendations:

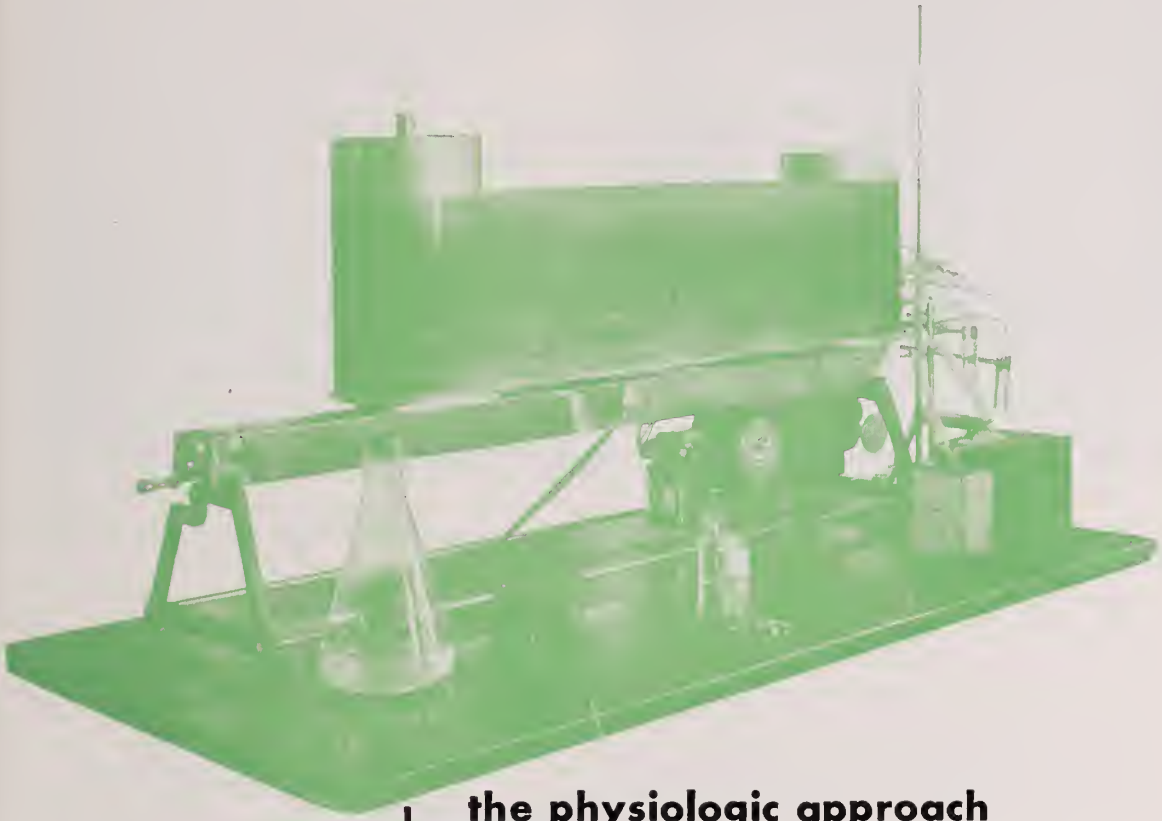
1. That a new ordinance be considered for the City of Providence based on a model ordinance regulating eating and drinking establishments drafted by the United States Public Health Service.
2. That the Department of Health, as the responsible agent for the enforcing of such an ordinance, be provided with the necessary staff of inspectors.
3. That at least annually an educational program be planned and carried to completion for the education of both management and employees of eating establishments relative to the reasons for and importance of the various sanitary standards. Each restaurant manager and employee should be required to take this brief course once, as a prerequisite to obtaining or renewing a food dispenser's license or food handler's permit.

The adoption of these recommendations would be a major step towards one aspect of effective public health protection within the City.

The model ordinance, submitted herewith, or one based thereon, is now in effect statewide in 16 States and the District of Columbia, as well as in more than 176 counties and 380 cities located in 37 states and territories with a population coverage of over forty million.

The Association feels strongly that any ordinance adopted will fall far short of its purpose unless the agency responsible for its enforcement is adequately staffed. We have noted that the Spe-

continued on page 812



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*Goldthwait, J. E., Brown, L. Y., Swaim, L. T., and Kuhns, J. G., *Body Mechanics in Health and Disease,* 103-105, J. B. Lippincott Co., Philadelphia, 1937.

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SANITATION IN EATING ESTABLISHMENTS

continued from page 810

cial Committee on Sanitary Investigation of the City Council has recommended the addition of two qualified women inspectors. We support this recommendation with the qualification that the limit not be set at two if adequate enforcement for the protection of the public requires more than that number of additional inspectors.

Also, evaluation should be made biennially of the program in Providence by district specialists of the Public Health Service, and sanitation ratings should be sought through the same Service both to measure the results obtained and to stimulate improvement.

It is not sufficient that legislation be enacted and enforcement attained only through legal procedures. The education of the owners and managers of eating establishments and of food handlers provides a most effective method of securing compliance with the sanitary standards through understanding of the purposes and of reasons for the various regulations. There is little doubt that such programs, if successfully carried out, would simplify the work of the inspectors, thus lessening the cost of enforcement.

At a time when millions of dollars are to be expended to halt the pollution of Narragansett Bay, and the other waters of the State, and when an enlightened public should be conscious of dangers to its health through lack of sanitary procedures in general, the Association is at a loss to understand the general apathy towards cleaning up the eating and drinking establishments in Providence, and in the State. The cost of such sanitation is negligible; the return in protection of good health is beyond estimate.

The Providence Medical Association, representing the doctors of medicine of the Greater Providence area, offers its complete support to the City Government, and to any other interested agency in efforts to bring about the highest possible standards of sanitation throughout the community.

Committee on Legislation,

FRANK B. CUTTS, M.D., *Chairman*
ALBERT H. JACKVONY, M.D.
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THE MEDICAL RECORD LIBRARIAN OF YESTERDAY, TODAY, AND TOMORROW*

MARY NUNEZ, R.R.L.
The Memorial Hospital, Pawtucket, R. I.

WE, medical record librarians from all over this great country of ours, are meeting together at this convention to obtain and exchange as much knowledge as possible in medical library science that we may continue to serve our hospitals to the best of our ability. This is a sacred trust handed down to us from the record clerks of yesterday and those associated with them in the establishment of our profession.

With specific reference to the medical record librarian of yesterday, let us pay tribute to the five charter members of the group from the state of Massachusetts known in 1916 as "The Club of Record Clerks" for their initiation of education in this branch of hospital work. Among this group were Mrs. Grace Whiting Myers, our beloved honorary life president, from the Massachusetts General Hospital, Miss Florence G. Babcock, of the Peter Bent Brigham Hospital, Miss Leona M. Corcoran, of the Boston City Hospital, Miss Molly C. Bisbee, of the Massachusetts Eye and Ear Infirmary, and, Miss G. L. McCabe, of the Carney Hospital. Later, the name of the club was changed to "Association of Record Clerks" and finally became the Eastern Branch, Massachusetts Association of Hospital Record Librarians. At this point, let us also acknowledge the invaluable contribution made by the American College of Surgeons and individual medical men, interested in this original group. They gave generously of their time, teaching and guiding these women in a better understanding of their work. In 1928, the College invited the record clerks from every state in the union to meet with them in Boston and after this meeting was adjourned, the American Association of Medical Record Librarians was born on October 11, 1928.

You all know that the main objective of our association is "to elevate the standard of clinical records in the hospital, dispensaries, or other distinctly medical institutions; to serve as a means of intercommunication among record librarians; and to encourage the training of record librarians to the end that they may render intelligent service in that capacity, and thus assist in the promotion of efficiency in hospitals, dispensaries, or other distinctly medical institutions". This includes helping those least experienced in the profession.

As I unfold for you the major accomplishments of our association since its beginning in 1928, you will find that this main objective has ever been constant in the minds of our capable leaders for which they deserve great praise.

In 1929, the constitution and by-laws were adopted at a meeting in Chicago. In this same year, a committee was appointed to plan a course of study for medical record librarians. At the present time, we have eleven schools approved by the Council on Medical Education of the American Medical Association. Further methods of education being carried out are institutes, conventions, in service courses of five day programs to aid untrained workers, textbooks on medical record library science, a standard nomenclature of diseases and operations, an association bulletin and the formation of local and state affiliated associations.

In 1932, the Board of Registration was formulated to provide registration for all qualified medical record librarians. The requirements for registration are very democratic and most adequate. Equal opportunity is given to the graduate of an approved school and the non-graduate medical record librarian who has served in a hospital and actively engaged in all phases of medical record work for the required time. The rules for registration reveal the wisdom and true sense of value of those who composed and approved them.

The medical record librarian of yesterday had problems and overcame them. The medical record librarian of today and tomorrow will also have them. If the past is any indication of the future, their problems will be met satisfactorily. A pertinent problem at the present time is to increase the number of qualified medical record librarians. Statistics noted in the Hospital Number of the Journal of the A.M.A., Vol. 133, No. 15, reveal that in 1946, there were 6,280 registered hospitals in this country, 3,819 full time medical record librarians, and 1,018 part time. The mattter of adequate training is necessarily involved. In our plan for the future, a word of caution is indicated.

In one of our closely allied professions, it is the opinion of experts that there has been a trend in overspecialization which has resulted in a great gap and a deviation from its main purpose. This is very

continued on page 819

* Presented before the American Association of Medical Record Librarians, at New York City, September 10, 1947.



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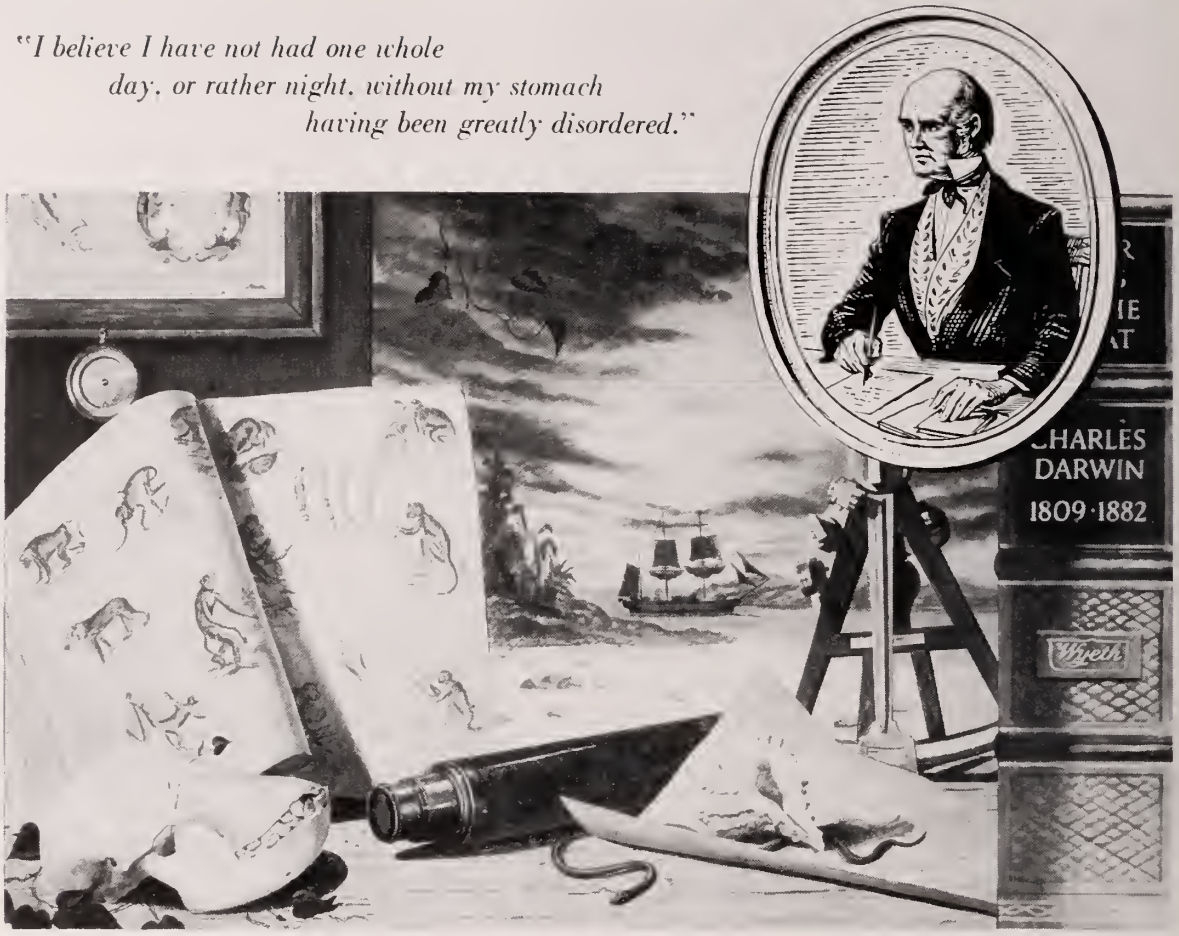
1. Editorial: J. A. M. A. 127:1056, 1945
2. Moore, et al: J. Clin. Investigation 23:547, 1944
3. Reznikoff and Goebel: J. Clin. Investigation 16:547, 1937

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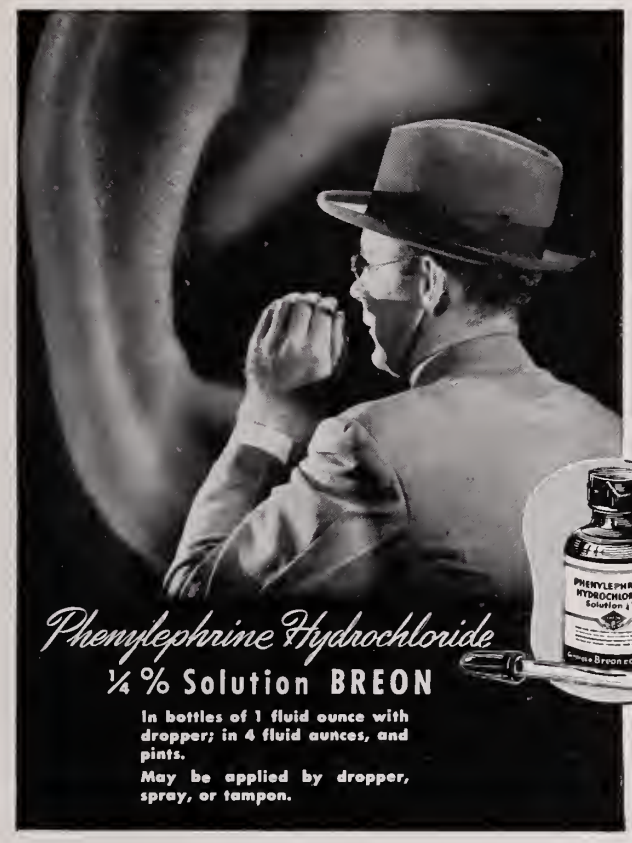
[1]*Rehfuss, M. E., The Ulcer Life, Clinics 3:480-493 (Oct.) 1944*

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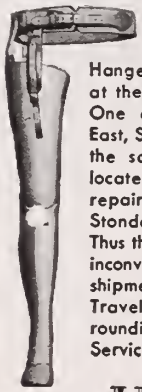
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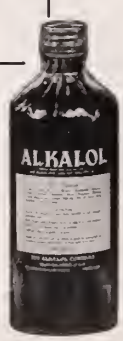
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THE MEDICAL RECORD LIBRARIAN

continued from page 814

unfortunate. It has not only happened in this closely allied profession, but is prevalent in other fields. Let me quote from a recent article by President Henry M. Wriston of Brown University, noted in the *American Magazine* "The ever-growing tendency on the part of business, industry and some government agencies to make a degree a prerequisite for a position places a false value on the degree. Thousands of students now attend college not so much to gain an education as to obtain degrees which will serve as 'passes' to desirable positions and advancement after graduation. Such a condition is a menace to our democratic way of life. It threatens real education, since it tends to convert colleges into assembly lines for the production of degrees, instead of institutions where minds are enlarged and personalities developed." The article further states that a degree "can mean much or absolutely nothing, depending upon the college bestowing it as well as the competence, character and personal integrity of the individual reaching it. . . . The current tendency to encourage degree chasing is hostile to true education. . . . Enlightenment is not a matter of degrees and we have been too contemptuous of the intelligence of the common man. His capacity for sound judgment has been far too heavily discounted . . . possession of a degree is not a correct criterion of ability."

There is no doubt of the progress made by the record librarian of yesterday and today. I say yesterday and today for we are fortunate in being a young organization as this association will be only 19 years of age on October 11, 1947. We have as leaders of today, medical record librarians of yesterday. The past and present record of our association is one of which we may be justly proud. Our pioneers in this field faced hardships and overcame them by ability, hard work, sacrifice and courage. They had the spirit of humility which is capable of great endurance. Our path has been made easier and we are indebted to these leaders and also to the American College of Surgeons, the American Hospital Association and the Council on Medical Education of the American Medical Association. Like the record librarian of yesterday, we are grateful to individual members of the medical profession and administrators for their continued advice and support.

As we go forward into a bright future, with hope in our hearts, and the past of our association as an inspiration, let us renew our determination to continue in our main objective, wisely and democratically, and thus, serve our hospitals to the best of our ability and safeguard the sacred trust of the record clerks of yesterday.



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*Lehr, D.: Proc.Soc.Exper.Biol. & Med. *58*:11 (Jan.) 1945

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Medicine Versus Public Health The same hall at Atlantic City that echoed with the cheers of acknowledgment for the great achievements of American Medicine during the past century as the A M A met in its glorious Centennial Celebration last June, echoed anew with condemnation of the A M A when the 75th year celebration of the American Public Health Association was held on October 9. To a spectator at both events the experience was unique. In June the felicitations of the world for leading in the progress to create better health for all people; in October the attacks (received by thunderous applause by health and social welfare workers) of the spokesman for the national organization of health officers, nutritionists, public health nurses, sanitary engineers, health educators, and school health officers.

Chief attacker of the A M A was aging Dr. C.-E. A. Winslow, editor of the Journal of the American Public Health Association, and professor emeritus, Yale School of Medicine. Said public health educator Winslow to some 2,500 enthusiastic hearers:

". . . Nor is there the slightest possibility that programs of voluntary insurance, such as the Blue Cross and Blue Shield plans, can meet the emergency. They are of great value in spreading the cost of medical care on an actuarial basis . . . they cannot . . . be expected to meet the needs of the large group of families which cannot budget even the average cost of medical care.

"This situation has been met in the Soviet Union by State Medicine . . . the only alternative which has been found practicable in other countries is a system of Compulsory Sickness Insurance. . . ."

"Legislation for adopting a national policy of Sickness Insurance has been introduced in recent sessions of Congress. . . . These measures have made no headway as yet, chiefly on account of the opposition of the American Medical Association, which has played in this connection a parallel role to that assumed by the National Association of Real Estate Boards in connection with housing. The statements prepared by Mr. Herbert Nelson of the latter organization are identical in ideology and general phraseology with the fulminations of the National Committee of Physicians."

New York Chiropractors The public relations committee of the New York State Medical Society has recently made some extremely interesting observations on the inadequacy of the Medical Practice Act of that state as it relates to the prosecution of chiropractors. The problem is a vexing one in the Empire State as chiropractors are not licensed, yet they publicly advertise and carry on their work subject to prosecution only if they perform one of the acts within the definition of medicine in the Education law. The big difficulty is to obtain evidence for successful prosecution as the law requires that complaints to the Department of Education against illegal practitioners must (1) be made in writing, (2) must be investigated and verified by a medical inspector, and (3) if the facts complained of are found to be true the complainant must testify in person against the defendant at the subsequent trial. The net result: 50% of the complainants lose interest in the matter; a large percentage of the rest become discouraged as the Department attempts to secure the evidence.

Other highlights of the report indicate that most chiropractors have a brochure and pictures of the members of the Medical Inspection Staff and hence are immediately alerted when under surveilance; that in many instances the court permits the introduction of so much testimony regarding the claimed value of chiropractic that the jury loses sight of the main issue—the practice of medicine illegally; and that the chiropractic society is highly organized with legal counsel and public relations staff.

Closing The Golden Gate The Health Service System for the city employees of San Francisco, like most compulsory systems, started out by promising too much for too little in an attempt to stifle opposition to its compulsory payroll deduction features. And, like most socialized medicine systems, when financial difficulties developed it first siphoned off funds needs for medical services to help defray the cost of bureaucratic overhead. When that failed to balance the books the

continued on page 822

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THROUGH THE MICROSCOPE

continued from page 820

System increased its rates to the insured members, and then took the final step, characteristic of all experiments in socialized medicine, by demanding that doctors lower the quality of medical and hospital care provided their patients. Such is the statement made recently by the San Francisco County Medical Society.

Resignations of 880 doctors from the professional staff of the Health Service System have been received by the County Medical Society to become effective immediately when submitted by the Society to the Board on November 10 unless reorganization of the system on a sound medical basis acceptable to the medical profession is accomplished prior to that date. Regardless of the course of action by the Board the Medical Society guarantees that there will be no interruption in the medical care of city employees as they will be treated as private patients regardless of their ability to pay.

The golden era—for the bureaucrats—of this city compulsory program is apparently ended. The experiment has failed. The medical profession has demanded — and will undoubtedly secure — the adoption of a non-compulsory system for San Francisco comparable to the State and the Los Angeles city employee systems.

If You Have No Worries . . . A simple test, which can be self-given, which will determine whether you run a danger of becoming either an excessive drinker or an alcoholic or not, if you drink, long sought both by drinkers and medical men, is established by recent work on the problem by many agencies.

The test is not a perfect one as it does not establish a drink quotient, and, to the fifty-five million estimated moderate drinkers, offers little guidance in the quantity or method or character of in-take.

If you have NO worries about love, health, family, appearance, income, job, the United Nations, Unions, high cost of living, politics, the state of the nation or the world, education, ability, present, future or past,—on the basis of scientific studies you may drink intoxicants as you will, with little danger that you will become diseased as a result, or excessively addicted to them. This conclusion, The American Business Men's Research Foundation says, is based upon the scientific findings* that, of all alcoholics (chronic) examined in scores of state institutions, including hospitals and asylums, newly established alcoholic clinics and old time "cures", by competent medical men, no one has discovered one single case of alcoholism (chronic)

**Note:* Scientific source data for above statements are available on request from The American Business Men's Research Foundation, 53 West Jackson Boulevard, Chicago 4, Illinois.

in which the victim had *no* troubles or worries, (and to make it worse) real or imaginary.

All Things Considered Such was the title of a daily feature column for almost fifteen years in the *Chicago Daily News* by author Howard Vincent O'Brien. We thought of one of those columns recently when we read the Associated Press story of O'Brien's death from cancer. Ill with the disease for more than a year, O'Brien wrote from his hospital room that "it was near the base of the spine, a most inaccessible spot. It was fastened to everything in the region so that getting it out involved considerable damage to adjacent and innocent property."

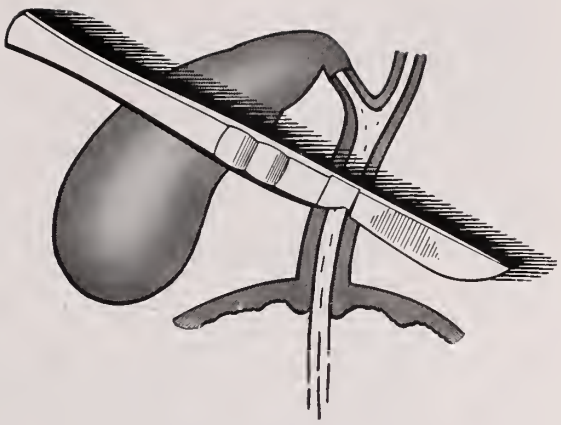
We thought of a column he published on September 6, 1940 which was subsequently widely publicized by the National College of Chiropractic. In that column he told of advising a young man to be a chiropractor because "whatever its status in the art of healing, chiropractic certainly seems to be a good business. The one I know runs through as many as 60 patients a day, each paying the flat rate of $2 per treatment, cash in advance."

We wonder if the young man took the advice, and if other young men who read the column followed the counsel, and if they, too, run through sixty patients daily. And we wonder how many cancerous conditions they detect by chiropractic treatment in such "run throughs".

Benefit Shoe Foundation Bristol, Rhode Island, now lays claim to the first shoe organization of its kind in the history of footwear in the Benefit Shoe Corporation. A humanitarian service, this non-profit corporation is a project of Dr. Dale D. Dutton, a former Baptist minister. The corporation plans to make available regular standard make shoes, singly or in mismated pairs—to amputees, paraplegics, and others with mismated feet. Any profit from the sale of shoes will be directed to humanitarian and welfare agencies.

Noted In The News The eighty-nine voluntary, non-profit hospital members of the United Hospital Fund of New York reported a total operating deficit of near $4½ for 1946—two and a half times the deficit of the preceding year. . . . Initial steps in the development of an organized public relations program by the Florida Medical Association have been taken with the approval of a charter for the Florida Academy of Public Medicine, a new corporation whose primary objective will be the dissemination of information to the public of the work being done by the Florida physicians in the interest of the health and welfare of the people. . . . Bobby Brown, pinch hitter for the World Champion Yankees, has resumed medical studies at Tulane. . . . In

continued on next page



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THROUGH THE MICROSCOPE

continued from preceding page

Montreal recently a physician was sentenced to be hanged for murder in the death of a 23 year old girl on whom he performed an abortion. . . . Dr. R. R. Sayers, medical director, U. S. Public Health Service, and director of the U. S. Bureau of Mines since 1940, has been granted a leave to accept the chairmanship of the medical board of the welfare and retirement fund of the United Mine Workers of America. . . . The state of Indiana has recently enacted an annual registration law for physicians, hence any one holding such licensure in that state should report to the state board of registration to avoid having his license revoked. . . . The number of mid-wife deliveries in New York City has decreased from a total of 49,616 in 1909 to a mere 251 in 1946. And in Providence only one or two mid-wife deliveries were reported in the past couple of years, yet the state health survey law commission continued to set up licensure regulations for the practice of mid-wifery in this State. . . . One of the first acts of Norwalk's (Connecticut) new Socialist mayor Irving C. Frease was to name Dr. Edward J. Tracey as fire commissioner. Not a bad idea, at all. We know some physicians who would be assets to the Providence Bureau of Police and Fire.

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WORKMEN'S COMPENSATION ACT

Statement to the Workmen's Compensation Law Commission of Rhode Island by the Committee on Industrial Health of the Rhode Island Medical Society, at a public hearing, October 27, 1947.

THIS STATEMENT is submitted by the Committee on Industrial Health of the Rhode Island Medical Society in the hope that it will assist the Commission in its consideration of some of the medical phases of the compensation law. However, this Committee offers this statement subject to possible amendment by the House of Delegates, policy-making body of the Society, which alone has the authority to speak for the entire medical profession and which is not scheduled to meet again until late in November.

Importance of Medical Phases of Workmen's Compensation Law

Recognition of the fact that the greatest boon that can be conferred on the worker is not to hand him a meager cash stipend while he is disabled, but to restore him as quickly and fully as possible to a condition of health and productive employment has come slowly in the operation of the workmen's compensation law here. It is only in the past six years that the medical limits have been extended to aid the injured worker, allowing for unlimited care in unusual cases at the discretion of the director. Thus there has gradually come the acknowledgment that when all the functions at the various stages of compensation are examined that of medical care is the most important of the whole compensation situation.

This transition of emphasis from the administration of the cash phases to the medical and health phases should be encouraged. The fundamental reason for the workmen's compensation program is the welfare of the worker, and there can be no compromise with either the quality or the quantity of the services for the restoration of the worker to health and employment where the disability is partial, and to the best possible state of health where the disability is total.

In 1941 the limits for medical and dental service, and also for hospital care were increased. The following year provision was made for unlimited medical care for unusual cases as authorized by the director of labor. Besides, in addition to all other aid, the worker was made eligible to receive "all medical, optical, dental and surgical appliances and apparatus of any nature whatsoever—including but not being limited to the following: ambulance and nursing service; eyeglasses; dentures; braces and supports; artificial limbs; crutches and other similar appliances." This is action in the right direction in keeping with the fundamental conception of the place of medical care in the compensation program.

Therefore, this Committee recommends that the Workmen's Compensation Act provide for unlimited medical care to guarantee to every worker the assurance of every aid to restore him to health and employment.

Cost of Medical Care in Workmen's Compensation

The Rhode Island Supreme Court has clearly stated that "the workmen's compensation act has a beneficent design and it is to be interpreted with a liberality calculated to effectuate its purpose. The act is to be construed without regard to its immediate financial effect upon either of the parties."

Whether the act has been interpreted more liberally than even implied in this court opinion, or whether the administration of the act has been too costly, is not within the province of this Committee to state at this time. We are concerned, however with the implications, made at regular intervals, that the medical costs of the workmen's compensation program in this State are excessive. We deny that this is true as regards the services rendered by the physicians of the State, and we resent any implication that payments for medical care constitute some sort of donation to the physicians. On the contrary, medical care is a very essential part of the compensation given to the employee, for his benefit and not for the benefit of the physician, and the fact that it is given in service and not in cash does not in any way alter this fundamental fact.

In the past decade there has been little change in the charge for surgical procedures in workmen's compensation cases. And it is only in the past five years that the fee for home and office visits has been increased by one dollar for all patients. Hence any rise in the total cost of medical services under the workmen's compensation program cannot be attributed to excessive charges by physicians. The only change of excessive physicians fees advanced by either the chief of the division of workmen's

continued on page 828



"Beginner's luck" isn't always good

The good luck so often attributed to beginners can't be counted on in infancy. Here the "beginners" often meet insurmountable obstacles which have raised the proportion of infant deaths within the first 30 days to 62.1% of the total infant mortality.* During this hazardous first month proper selection of the first formula is therefore of vital importance.

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*Vital Statistics—Special Reports: Vol. 25, No. 12, National Office of Vital Statistics, Washington, D. C. (Oct. 15) 1946, p. 206.

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WORKMEN'S COMPENSATION ACT

continued from page 826

compensation or the insurance industry to this Committee has been made within the past six months. These charges were directed against the seemingly excessive bills and unduly prolonged treatment by a few physicians—less than 1 per cent of all the physicians in the State—for diathermy treatments. This Committee, for the Society, offered both the compensation division and the insurance representative complete cooperation in controlling any abuse whatever in the medical phases of the entire program, and guaranteed to discipline any member of the Society against whom such charges may be preferred.

Since most of the blame falls unjustly upon the physicians when the cost of the medical phases are discussed, the Committee believes that a clearer interpretation of the issues involved is necessary. The only factual statistics immediately available are those from the annual reports of the workmen's compensation division of the Rhode Island Department of Labor which, while probably not the complete analysis of the program, offer concrete statistics that are a true index of the situation. Figures for four fiscal years in the period from 1939 through 1946 are listed in Chart I as submitted.

The reporting in this manner to the General Assembly and to the public generally of the sum total paid for medical attention and hospital services creates the opportunity to blame the physician for any and all rises in costs. The fact that the term medical attention includes also dental care, all medical, dental, optical and surgical appliances and appartus whatsoever, including ambulance and nursing service, is overlooked.

Again, the sharp rise in the medical and hospital expense from 1939 to 1942 is readily accounted for when one notes the more liberal legislation enacted within that period. In 1941 the medical-dental maximum was increased from $200 to $300, and to $500 for claimants hospitalized more than 14 days, and the per diem hospital allowance was increased from $3 to $4.50, plus allowance for extras (approximating an average of $1.50 per day) such as x-rays, laboratory services, etc. In his report to the General Assembly in 1941 the Director of Labor noted that "the amendment also included a safeguard against over-charging by physicians, and authority to determine the reasonableness of medical charges was given to the Department of Labor."

In 1942 the Act was amended to provide for unlimited medical care in unusual cases as authorized

Chart I

WORKMEN'S COMPENSATION STATISTICS

(Abstracted from annual reports of the Department of Labor)

	Oct. 1, 1939 to Sept. 30, 1940	*Oct. 1, 1941 to Sept. 30, 1942*	*Oct. 1, 1942 to Sept. 30, 1943*	*Oct. 1, 1945 to Sept. 30, 1946*
Employees	156,150	209,791	239,744	247,191
Accidents for which compensation was paid	4,469	7,920	8,258	6,831
Accidents requiring medical attention only	25,509	64,270	41,598	28,899
Compensation paid for disabilities	$ 604,511	$1,100,838	$1,626,287	$4,170,263
Dependents due to death	$ 57,243	$ 74,859	$ 148,444	$ 105,597
Medical Attention and Hospital Services	$ 342,579	$ 679,837	$ 680,884	$ 692,772



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by the director of labor, and in addition to all other aid the claimant was made eligible for appliances and apparatus of any nature whatsoever, including but not being limited to ambulance and nursing service; eyeglasses; dentures; braces and supports; artificial limbs; crutches and other similar appliances.

In 1943 the Curative Center was established. Within the present year the per diem hospital rate has been increased from $4.50 to $8.00, plus allowance for extras, which will probably average $3.00 per day.

These provisions have undoubtedly been the major causes for the upswing in the total medical and hospital sums noted in Chart I. But reference must be made to the steadily increasing rise in the number of industrial accidents reported annually by the division of industrial inspection, as indicated below:

Chart II

TOTAL INDUSTRIAL ACCIDENTS

(Abstracted from reports of the Division of Industrial Inspection, Rhode Island Department of Labor)

1940	1941	1942	1943	1944	1945
4,711	7,439	9,497	9,429	9,474	9,109

Analysis of the most frequent types of injury in the leading industries gives further indication of the rapid increase from 1940 to 1944 of certain disabilities, and of the consequent involvement of medical attention and hospital service.

Chart III

MOST FREQUENT TYPES OF INJURY IN LEADING INDUSTRIES

(Abstracted from reports of Division of Industrial Inspection, Rhode Island Department of Labor)

	1940	1944	1945
Strains from lifting	514	2,000	2,104
Struck against	968	1,635	1,700
Slips, causing strains (NOT FALLS)	273	490	446
Falling, sliding, or flying objects	736	1,344	1,155

The annual reports of the division of workmen's compensation highlight this increase in industrial accidents. In 1941 the Assembly's attention was called to the fact that "the war and the attendant industrial effort . . . has created an unusual amount of industrial activity. A great deal of overtime work is being done and a great number of untrained workers have been put on the payrolls. As a consequence, the accident rate has increased to a great extent."

Again, in 1942, the report cited that the year "brought a greater increase in the activities of the division. Employment and industrial accidents, both higher than any previous year, caused gains in the number of accident reports, agreements and settlement receipts." And in 1943 reference is made to the fact that "the upward trend in the number of compensation cases which was noted in 1942, has continued during 1943, principally because of abnormal employment conditions."

Fixed Schedule of Fees

As noted above there has been no complaint by the division or by insurance carriers in meetings with this Committee of any excessive charges by physicians. The Society has no fixed schedule, and the charges made by physicians are the prevailing ones for similar treatment of injured persons when such treatment is paid for by the injured person. By experience the insurance carriers are familiar with the prevailing rates, and any fixed schedule would have to be drafted on such a basis.

If proponents of a fixed fee schedule for physician's charges see in such a mechanism a means by which fees may be reduced from time to time to the advantage of the employer and the insurance carrier, and to the disadvantage of the worker and the physician, the former being relegated to the part charity patient category, and the latter denied equitable payment for services rendered, their proposal is condemned strongly.

A fixed schedule of fees would not alter in any manner the cost of physicians' services under the act. As noted before, few changes have been made in the charges for surgical procedures for claimants under the workmen's compensation program, and the only general increase in medical fees has been that of a dollar for home and office visits for all persons.

The act already provides the director of labor with the authority to determine the reasonableness of medical charges, and also to set the fee for impartial medical specialists.

continued on next page

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WORKMEN'S COMPENSATION ACT

continued from preceding page

Medical Society Participation in the Program

The Rhode Island Medical Society, as the official organization of the medical profession of this State, has always been willing to assist in every way possible in the successful operation of the workmen's compensation program. Unfortunately, however, the advice, counsel, or opinions of the Society are seldom sought, and the present invitation of this Commission marks one of the rare instances when official invitation has been extended to express views on any of the medical phases of the act.

Legislation—however commendable it may have been—has been presented to the General Assembly and although it often affects the physicians of the State who are faced with the task of supporting and carrying out the regulations, little effort is made to secure their viewpoint in advance. Therefore, any criticism of any such legislation by the Society has to be made to the Assembly, thus creating the impression that the medical profession is obstructing the passage whereas its true intention is constructive. By administrative law, rulings affecting health care are promulgated, we believe, not always in the best interest of the worker, but the physician has to accept the regulations. Criticisms have been made derogatory to the physicians of this State in the daily press that have subsequently been proved to be without justification.

Such situations could well have been avoided, and they certainly should not be repeated in the future. Neither the Rhode Island Medical Society nor its Committee on Industrial Health have any desire to interfere with the proper administration of the workmen's compensation program. It does seek the privilege to assist the insured worker who is the beneficiary under the act to secure the most complete medical and hospital care for his recovery from his disability. In view of the paramount importance of the medical phase of the program the Society should be consulted regularly, and most certainly should be permitted to express its views to the workmen's compensation agency, to the insurance carriers, to labor and to industry, individually or collectively, on any and all procedures involving medical care by the physician.

Therefore, this Committee recommends that the Rhode Island Medical Society be given equal representation with labor, industry, insurance, and the public, and with any other agencies equally interested in the program, on any Commission that may be considered for the administration of the law; and otherwise, that provision be made for a Medical Advisory Committee to be elected by the Rhode Island Medical Society to meet regularly with all groups concerned with the operation and the administration of the act, in order to clarify, amend, arbitrate, or otherwise aid in solving any medical problems that may arise.

Other Phases of the Law

We recommend full coverage for all occupational diseases: the greater utilization of the curative center; the preparation of better report forms to aid the claimant, the physician, and the administering agency.

The selection and assignment of impartial examiners, their reports, and the prevention of occupational accidents and diseases are among other matters upon which the Society, or this Committee, will undoubtedly wish to comment later.

Some of these issues could undoubtedly be solved to the satisfaction of all parties involved through conferences, utilizing this Committee, or a Medical Advisory Committee as noted in the recommendation above.

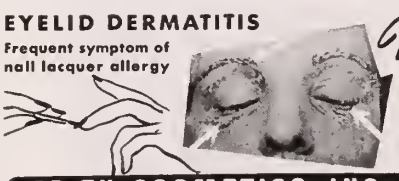
The Committee expresses its appreciation and thanks to the Workmen's Compensation Law Commission for this opportunity to make known some of its views on the subject.

Respectfully submitted,

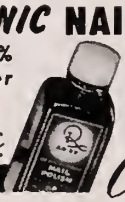
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DISTRICT SOCIETY MEETINGS

PAWTUCKET MEDICAL ASSOCIATION

A regular monthly meeting of the Pawtucket Medical Association was held on September 18, 1947, at 8:45 p.m. in the Nurses' Auditorium of the Memorial Hospital.

The meeting was called to order by President Earl J. Mara and the minutes of the previous meeting were read by the Secretary. They were accepted as read.

Dr. Mara then spoke in detail of the new prepaid surgical plan of the Rhode Island Medical Society and asked that the Pawtucket Medical Society give either its approval or its rejection of the plan. After lengthy discussion, the plan was unanimously accepted.

Dr. Mara then introduced the guest speaker, Dr. Russel O. Bowman, Chief Biochemist, Rhode Island Institute of Pathology, who spoke on "Diabetes Mellitus — Physiology and Treatment." At the conclusion of his address Dr. Bowman answered numerous queries from the floor.

The meeting adjourned at 10:55 p.m.

Twenty-two members attended.

Respectfully submitted,
KIERAN W. HENNESSEY, M.D.
Secretary

KENT COUNTY MEDICAL SOCIETY

The September meeting of the Kent County Medical Society was held at Dr. Peter Erinakes' office September 9, 1947.

Preceding the meeting proper a film on Folic Acid in the treatment of Anemias was shown by a representative of the Lederle Pharmaceutical Laboratories.

Minutes of the June session were read and accepted.

Recent newspaper articles alleging and decrying the lack of medical response to emergency and night calls in Kent County were discussed briefly. It was noted that physicians were available daily throughout the county, that the vast majority of so-called emergencies — even though answered — were really inconsequential or of unnecessary nature by persons who had not the foresight or desire of having a family doctor, and that the whole situation was highly overemphasized bearing an air of "much ado about nothing."

Dr. Russell R. Hunt, Radiologist at Roger Williams Hospital, presented a series of films demonstrating the value of X-Ray in Obstetrical problems.

The meeting adjourned at eleven o'clock.

Respectfully submitted,
FRANCIS D. LAMB, M.D.

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, October 6, 1947. The meeting was called to order by the President, Dr. Guy W. Wells at 8:35 p. m.

With the permission of the members present the Secretary was excused from the reading of the minutes of the previous meeting. The Secretary reported for the Executive Committee as follows:

"At the recent meeting the Executive Committee, among other matters, took the following actions which it reports to the Association:

It voted to offer a first prize of $50 and a second prize of $25 for the Case Report Contest for residents and house officers of hospitals in the district.

It voted to refer to the Rhode Island Medical Society the question of forming local chapters of the American Academy of General Practice.

It voted to have the President appoint a subcommittee of the Executive Committee to study the question of free afternoons of physicians in view of the public criticism of the universal practice of free Wednesdays, and it voted that this subcommittee shall make recommendations to the Executive Committee, and thence to the Association."

The report from the Executive Committee was accepted and approved.

Dr. Wells reported that the Obituary Committee consisting of Drs. Halsey DeWolf and Rodrigo Rego has prepared and submitted to the Secretary the Association's tribute to the late Dr. Victor P. daCunha Rego who died on June 22, in Lisbon, Portugal.

continued on page 834

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DISTRICT SOCIETY MEETINGS

continued from preceding page

The Secretary reported that the Executive Committee recommends for election to active membership in the Association the following physicians:

Wilfred I. Carney of 185 Angell Street, Providence

Gertrude L. Muller of 100 North Main Street, Providence

On a motion from the floor both these physicians were unanimously elected to membership. Dr. Wells called upon Dr. Arthur H. Ruggles, president of the Rhode Island Medical Society, briefly to discuss the new prepaid surgical insurance plan. Dr. Ruggles concluded his remarks by submitting the following resolution for possible adoption by the Association.

"Whereas the Rhode Island Medical Society, after long and careful study, has adopted a program for Voluntary prepaid surgical and obstetrical insurance, and

Whereas the success of this program depends in great measure upon the complete cooperation of every physician in the State, and

Whereas the Providence Medical Association is the largest constituent district society of the Rhode Island Medical Society,

Therefore, Be It Resolved, that the membership of this Association record its endorsement of the Rhode Island Medical Society's surgical insurance program and further,

Be It Resolved that the membership of this Association demonstrate its approval and support of the surgical insurance program by enrolling promptly as participating physicians."

Dr. Ashworth seconded the passage of the resolution. There was no discussion and on a voice vote the resolution was unanimously adopted.

Dr. Wells introduced Dr. Cortez F. Enloe, Jr., of New York City who had served with the Army Intelligence Forces in the invasion of Germany and who had visited various concentration camps and had interrogated men responsible for the medical work done in these places. Dr. Enloe adressed the Association on the subject "The German Medical War Crimes".

He gave a very interesting talk with slides on the various unethical human experiments the Germans performed during the war, using inmates of concentration camps as subjects. Many of the German scientists involved were hanged for these crimes to society.

They experimented with humans in cold immersion tests and exposure to blizzards in various states of nude. Most of the subjects died. He stressed the fact that no purpose was served by all these experiments.

He then demonstrated and discussed their experiments in sudden pressure changes.

In their attempt to find a method for mass sterilization the Germans performed numerous experiments in human sterilization, using X-rays, drugs, scarifying solutions and surgery.

Bone, muscle, and nerve regeneration experiments were done at Buchenwald. Others he discussed were salt water experiments and experiments in an attempt to develop vaccines, particularly typhus. Experiments with mustard gas, poisoned bullets, and suicide methods were also performed.

Their minds, he concluded, were closed to the Hippocratic interpretation of medical ethics.

The meeting adjourned at 10:10 p. m.

Attendance 160.

Collation was served.

Respectfully submitted,

DANIEL V. TROPPOLI, M.D.,
Secretary

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*Harris, S.C.; Ivy, A.C., and Searle, L.M.: The Mechanism of Amphetamine-Induced Loss of Weight: *A Consideration of the Theory of Hunger and Appetite*, J.A.M.A. *134*:1468 (Aug. 23) 1947.

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MEDICAL LIBRARY NOTES

The Librarian of the Rhode Island Medical Society announces the recent addition of the following books:

AMERICAN MEDICAL ASSOCIATION
Morris Fishbein—A History of the American Medical Association 1847 to 1947. Phil., 1947.

ANESTHESIA
John Adriani—Techniques and Procedures of Anesthesia. Springfield, Ill., 1947.

BACTERIOLOGY
Thurman B. Rice—A Textbook of Bacteriology. 4th ed. Phil., 1947.

DIAGNOSIS
Herbert French & Arthur H. Douthwaite, editors—An Index of Differential Diagnosis of Main Symptoms by Various Writers. 6th ed. Balt., 1945 (repr. 1947)

DICTIONARY
W. A. N. Dorland—The American Illustrated Medical Dictionary. 21st ed. Phil., 1947.

HOSPITALS
Hospital Care in the United States. Commission on Hospital Care. N.Y., 1947.

OPHTHALMOLOGY
Sanford R. Gifford—Textbook of Ophthalmology. Revised by Francis H. Adler. 4th ed. Phil., 1947.

PSYCHIATRY
Edward A. Strecker, Franklin G. Ebaugh & Jack R. Ewalt—Practical Clinical Psychiatry. 6th ed. Phil., 1947.

PUBLIC HEALTH
Haven Emerson—Local Health Units for the Nation. N.Y., 1945. Gift of Miss Grace E. Macdonald, Librarian of the Library of the Rhode Island State Department of Health.

ROENTGENOLOGY
George W. Holmes & Laurence L. Robbins—Roentgen Interpretation. 7th ed. Phil., 1947.

CHARLES F. GORMLY COLLECTION
Keith Simpson—Forensic Medicine. Balt., 1947, (Lond., 1946)

GIFTS

We have been given 107 volumes from the library of the late Doctor R. Morton Smith by his wife and daughter. Other gifts were received from the Alcohol Information Press and the Linde Air Products Company.

Unbound journals were given to the Library by Irving A. Beck, M.D. and Frederic W. Ripley, M.D.

BEQUEST FROM CHAPIN ESTATE

Under the terms of the will of the late Anna Augusta Chapin, widow of Doctor Charles V. Chapin, the Rhode Island Medical Society received Doctor Chapin's medals.

These are the National Academy of Sciences medal, awarded for eminence in the application of science to the public welfare, 1928; the Sedgwick Memorial medal, awarded by the American Public Health Association for distinguished service in public health, 1929; and the Susan Colver Rosenberger medal of Honor, presented by Brown University, 1935.

Miss Agnes V. Davis, R.N.

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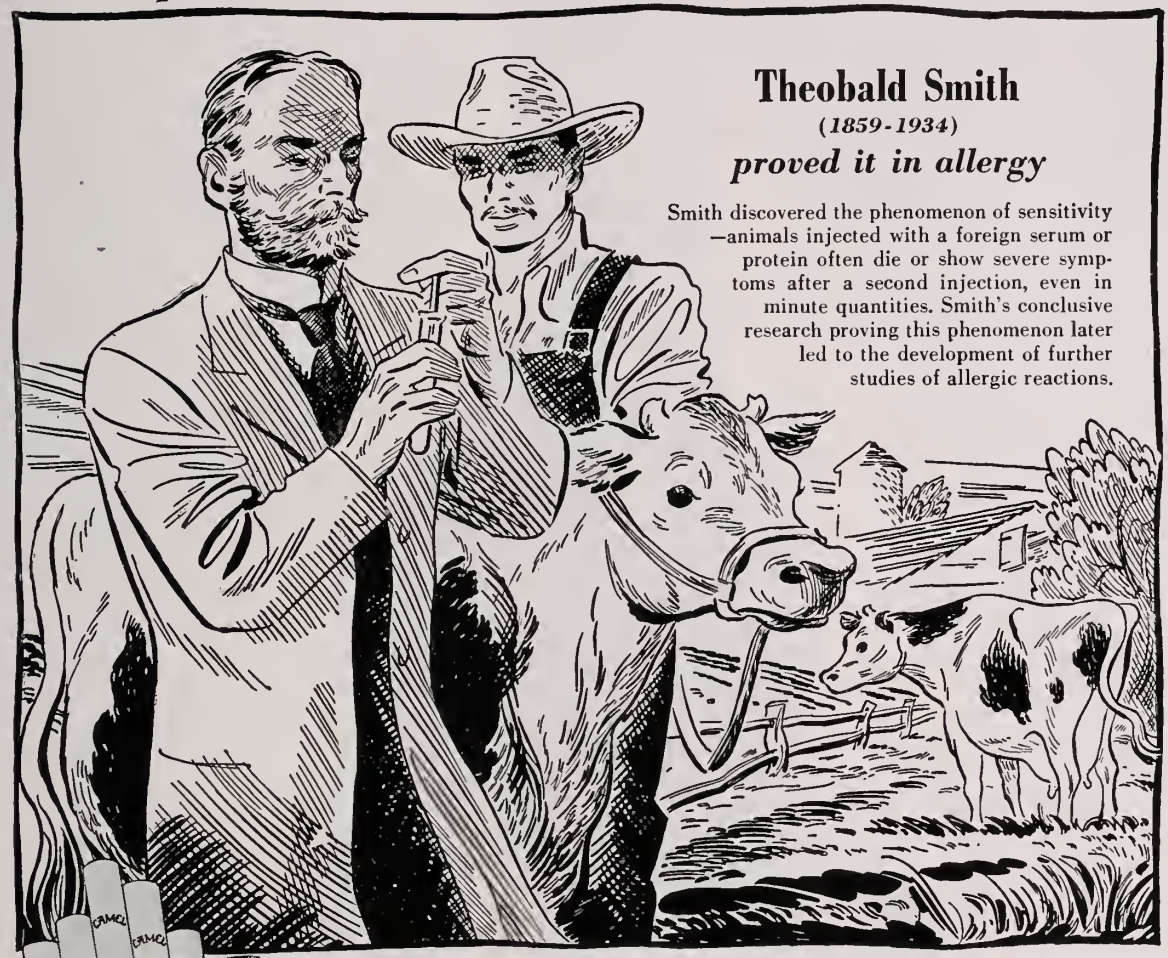
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WHEN BUYING INSURANCE . . .

Physicians are one of the main targets for mail order insurance companies. In the columns of this JOURNAL notices have been carried urging members of the Society to be certain a company is licensed in Rhode Island before purchasing any insurance contract from it. The following letter from the State Insurance Commissioner is published for the information of our members.

Dear Mr. Farrell:

In reply to your letter of October 16, we are setting forth below information concerning the American Standard Insurance Corporation of Indianapolis, Indiana which would be given by this Department to members of the public including physicians.

This Company is not entered or admitted to do business in the State of Rhode Island; therefore, there is no one in this State to accept service of process for any claim a policyholder may have against the Company. It is not permitted to employ any representative in this State to give service or information to its policyholders.

The best information that we could obtain from reliable sources was that the Company started business in 1930 and is listed as an Assessment Accident and Health Association. It appears to be licensed only in Indiana and apparently does a large portion of its business through the mails. At December 31, 1946, the Company had total admitted assets of $103,-688.00.

Under the circumstances and in view of the fact that this organization has not filed qualifications for entrance in the State of Rhode Island, we cannot recommend it to you as a resident of this State. It has been our practice in the past to discourage any participation in unlicensed, unauthorized and unadmitted insurance companies and associations.

If you have any further questions in this regard, we will be very glad to answer additional inquiries.

Very truly yours,

GEORGE A. BISSON,

Insurance Commissioner, State of Rhode Island and Providence Plantations

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YOUR DIRECTORY INFORMATION CARD

Preparations are now being made to publish the new, Eighteenth Edition of the AMERICAN MEDICAL DIRECTORY! The last edition of the Directory was issued late in 1942. Since that time, it has been impossible to publish a new edition because of wartime restrictions and the shortage of paper and labor.

About November 15, a directory card will be mailed to every physician in the United States, its dependencies, and Canada, requesting information to be used in compiling the new Directory. Physicians receiving an information card should fill it out and return it promptly whether or not any change has occurred in any of the points on which information is requested. It is urged that those physicians also fill out the right half of the card, which information will be used exclusively for statistical purposes. Even if a physician has sent in similar information recently, mail the card promptly to insure the accurate listing of his name and address. There is no charge for publishing the data nor are physicians obligated in any way.

The Directory is one of the most important contributions of the American Medical Association to the work of the medical profession in the United States. In it, as in no other published directory, one may find dependable data concerning physicians, hospitals, medical organizations and activities. It provides full information on medical schools, specialization in the fields of medical practice, memberships in special medical societies, tabulation of medical journals and libraries, and, indeed, practically every important fact concerning the medical profession in which anyone might possibly be interested.

Therefore, should any physician fail to receive one of these Directory Information cards by December 1, he should write at once to the Directory Department requesting a duplicate card be mailed.

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CASH SICKNESS COMPENSATION DATA

As reported in the Monthly Bulletin (Col. 1, No. 6, October 1947) of the Rhode Island Unemployment Compensation Board

BECAUSE OF the widspread interest in Cash Sickness, a summary of the program's experience during the past 30 months has been prepared for this report. The material will be found in Tables 1 and 2.

Table 1 summarzies the month-by-month payments for comparable periods in the years 1945, 1946, and 1947, and demonstrates quite clearly that there has been a definite downward trend in the Cash Sickness payments. Some of the reasons for this decline are mentioned in the footnote at the bottom of the table.

A summary of other Cash Sickness is given in Table 2 which requires rather careful analysis if the correct inferences are to be drawn from the data. It should be remembered that the claim load during the first six months of the benefit year (which begins in April) is substantially higher than it is during the last six months of the benefit year.

This is particularly true of the initial and continued claims because at the beginning of a new benefit year the claim load will represent the incidence of illness at that time, plus new claims which will be filed by disabled persons who exhausted their ceridts in the immediately preceding benefit year.

Some of the other items listed on Table 2 are not affected to such a degree by the change in the benefit year. These items include the medical examinations and the Board decisions.

In connection with this table it is interesting to note that during 1946 a total of 347,793 different individuals earned wages which were subject to the Cash Sickness Act. While this figure fluctuates from year to year, the general statement can be made that approximately one out of every ten covered workers in the state files a claim for Cash Sickness benefits and that the payments represent less than one compensable week of illness for each worker covered by the program.

Table I

Comparison of Net Cash Sickness Payments For Selected Years

	1947	1946	1945
January	$ 318,885.86	$ 340,461.00	$ 336,045.64
February	290,460.28	305,897.00	279,488.25
March	302,550.98	325,831.00	357,327.50
April	347,868.98	379,115.25	373,737.96
May	499,516.00	572,093.50	566,351.00
June	456,686.96	495,351.00	495,147.50
July	425,735.61	501,057.10	468,271.25
August	358,013.55	402,176.87	438,179.50
September	342,630.33	328,116.73	341,409.64
Total 9 months	3,342,348.55	3,650,099.45	3,655,958.24
Total for year	N. A.	4,606,211.09	4,668,796.24
9 months as a % of Total	N. A.	79.24%	78.31%

Cash Sickness Payments

Three factors are responsible for the downward trend which has been noted this year in the Cash Sickness payments. These are: changes in the law, the retirement of a number of older workers from the labor force and the return to household duties of thousands of women who entered employment as a patriotic duty during the war years. Because of the retirement of these workers, it is expected that the Cash Sickness claim load will be lower in future years than it was in 1945 and 1946.

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Table II

Cash Sickness Activities April 1945 to September 1947 Inclusive

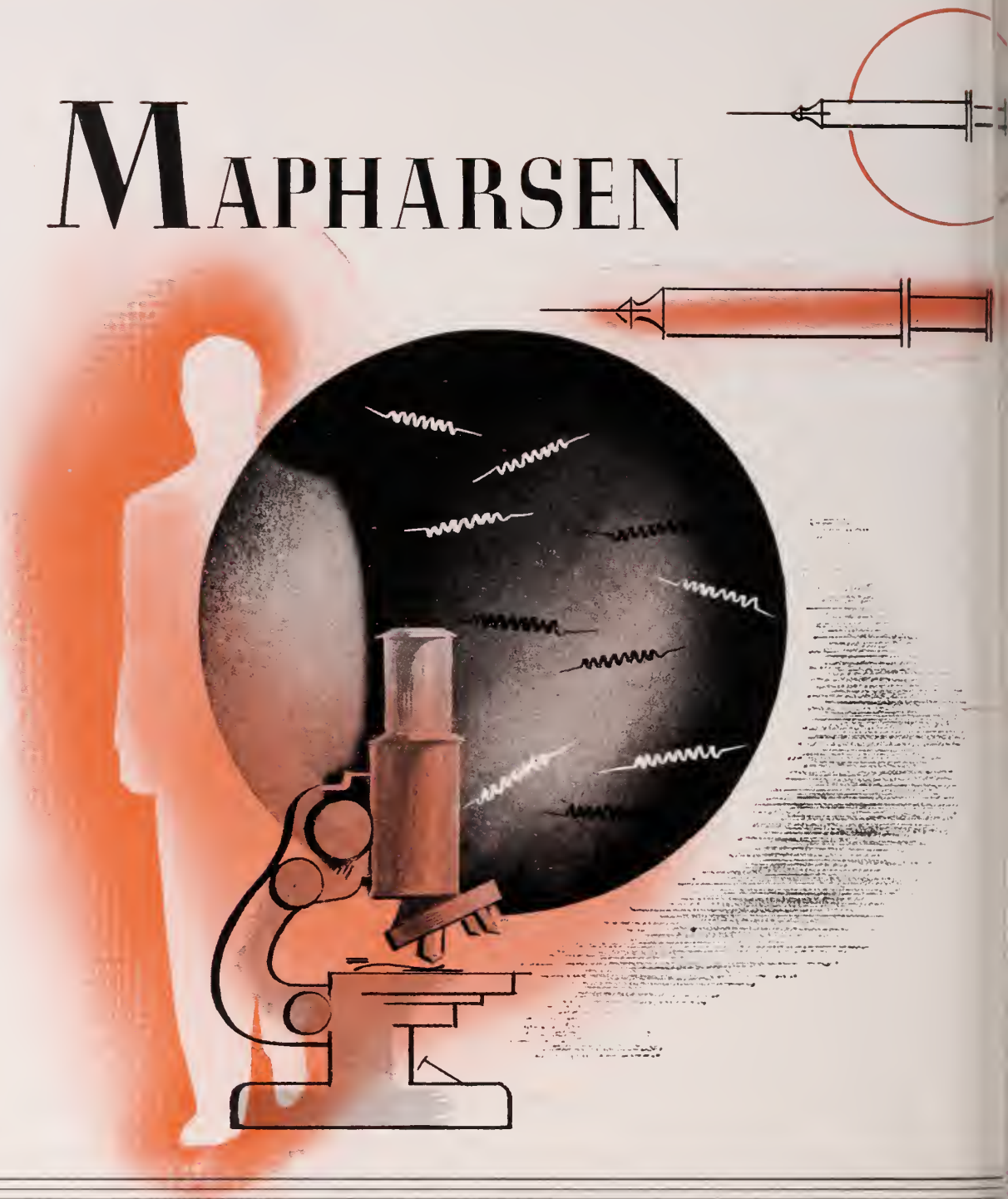
	April 1947-Sept. 1947	*April 1946-March 1947*	*April 1945-March 1946*
Initial Claims Received	19,768	35,173	36,189
a. Waiting Period	18,733	32,020	32,468
b. Refiles	1,035	3,153	3,721
Initial Claims Denied	1,235	2,368	2,132
Continued Claims Received	144,851	273,740	278,312
Continued Claims Denied	227	384	498
Medical Examinations			
Appointments Scheduled	10,176	22,444	26,885
Claimants failed to appear — claims denied	2,342	5,006	5,983
Claims denied after medical examination	1,051	2,521	4,452
Claims held up pending laboratory tests	146	380	692
Claims allowed after medical examination	6,269	13,539	14,754
Claims allowed pending laboratory tests	239	701	742
Claims referred to Board	129	297	262
Board Decisions	556	1,276	2,350
Claims Allowed	307	870	1,653
Claims Denied	249	405	687
a. Claimants reported	112	334	565
b. Claimants failed to report	37	71	122
Claims adjusted after hearing	—	1	10
Number of Payments	145,305	274,214	277,248
Amount of Payments	$2,430,451.43	$4,545,919.21	$4,668,123.85

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*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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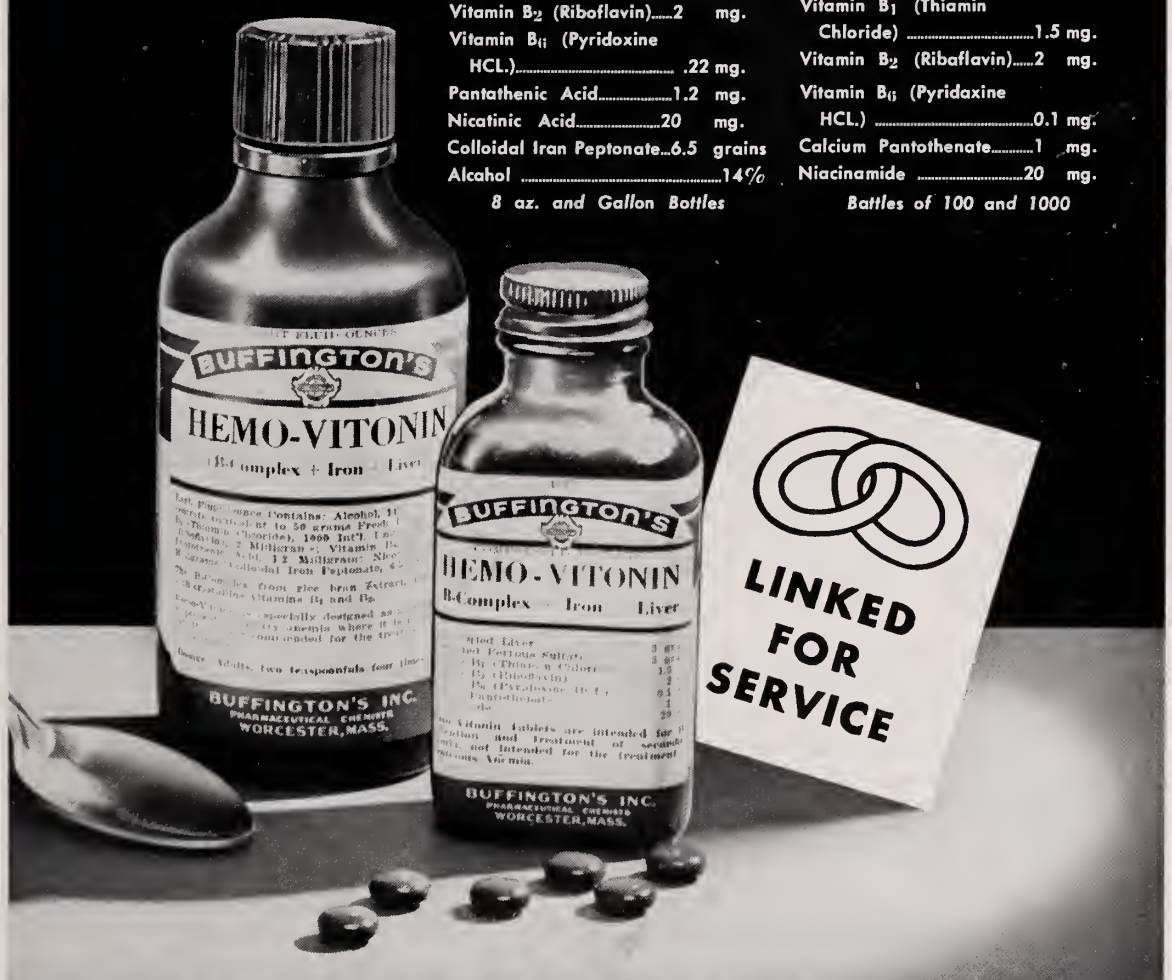
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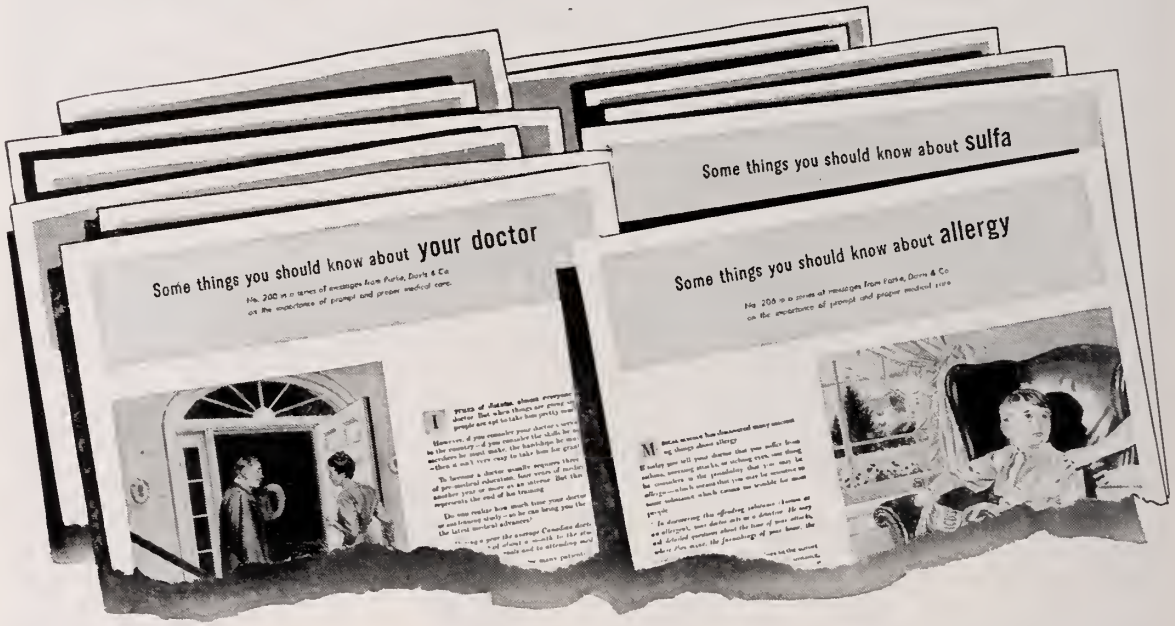
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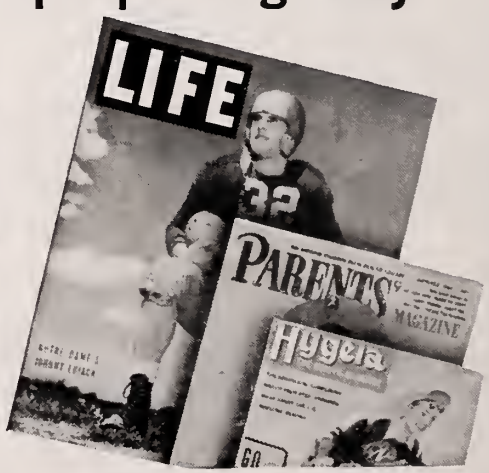


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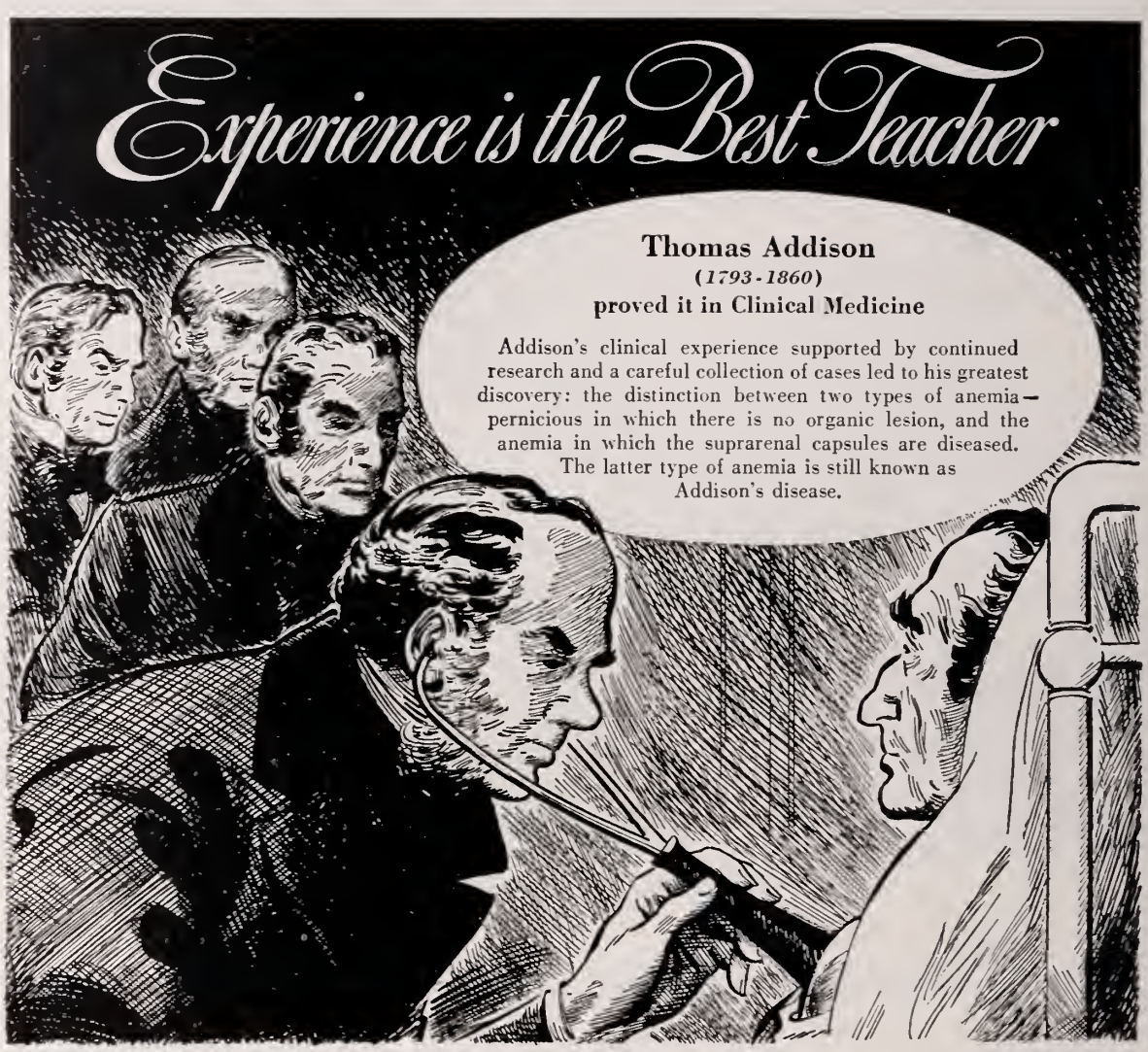
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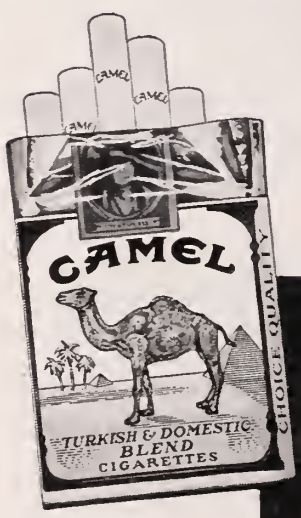
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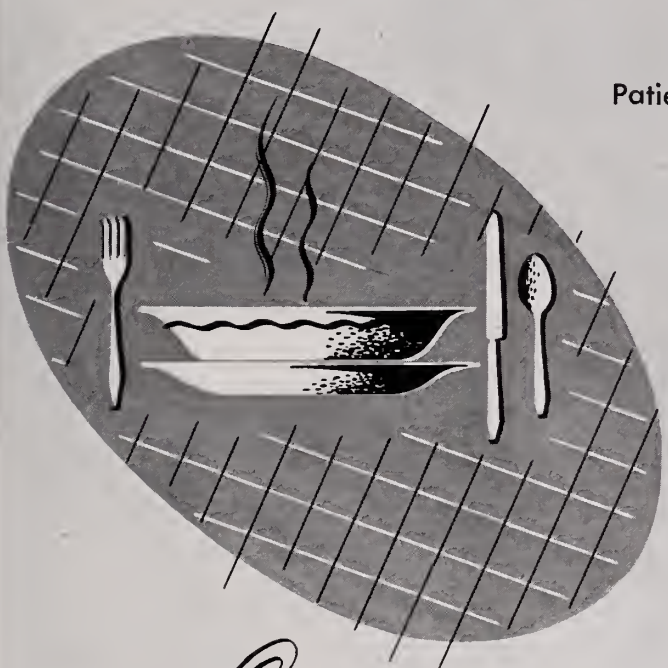
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*J. A. M. A. 129:1080. December 15, 1945.

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* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXX DECEMBER, 1947 NO. 12

THE CHARACTERISTICS OF ASTHMA IN INFANCY*

WILLIAM P. BUFFUM, M.D.

The Author. *William P. Buffum, M.D., Chief, Pediatric Service, R. I. Hospital, Providence.*

THIS STUDY is an attempt to determine the characteristic features of asthma when it occurs during the first two years of life. In spite of the fact that asthma begins very frequently during this period, and has a tendency to be serious, very little has been written about this disease in early life.

Asthma very frequently begins during the first two years of life. In analyzing 164 cases seen in private practice, 56 cases began their wheezing during this period. Eight years ago, Dr. Stanley Freedman and I reported on 101 cases of asthma in childhood[1] and of this group 29 had it before two. Adding the two groups together, there are 265 children of which 32 per cent had asthma before two years of age.

O'Keefe has reported a group of children in 22 per cent of which the asthma began before two years of age.[2] Chobot found that 29 per cent had this onset in his group.[3] So it seems clear that from 20 per cent to 33 per cent of asthma in childhood begins before the age of two.

TABLE 1

FREQUENCY OF OCCURRENCE OF ASTHMA BEFORE TWO

Analysis of 265 Cases of Asthma in Childhood

Number whose Asthma began before two	85 (32%)
Number whose Asthma began after two	180 (68%)

Both of the groups, comprising in all 265 children, were studied to see what relationship there was between the age of onset and the severity of the symptoms. Of the 85 cases with onset before two years of age, 32 per cent were classified as severe, and of the 180 cases with onset after two years of age, 20 per cent were considered severe. This supports the theory that asthma beginning before the age of two, is more likely to be severe than that beginning in later childhood.

TABLE 2

RELATIONSHIP BETWEEN THE AGE OF ONSET AND THE SEVERITY OF ASTHMA

	Mild	*Severe*
Asthma beginning before two	56 (66%)	29 (34%)
Asthma beginning after two	143 (80%)	37 (20%)

Thirty-eight of these patients were seen before the age of two and their asthma studied at that time. Of these, seven were seasonal cases with their symptoms chiefly in some period of the warm weather. Fourteen were persistently wheezy with no evident seasonal variation, and among these were most of the more serious and difficult cases. Ten were wheezy only with colds, but none of the four cases with completely negative skin tests were in this group. Seven had wheezing in spells which were not obviously respiratory infections.

TABLE 3

INFANTS UNDER TWO YEARS WITH ASTHMA. CLASSIFICATION OF CASES BY SYMPTOMS

Wheezingly with colds	10
Seasonal wheezing	7
Persistent wheezing	14
Wheezing in spells (non-seasonal)	7

The allergic inheritance is very evident in these patients. Twenty-one had a family history of asthma or hay fever on either the paternal or the maternal side, and an additional five had such inheritance on both sides. Twelve had no such inheritance.

continued on next page

* Presented before the Providence Medical Association, at Providence, November 3, 1947.

[1] Buffum, W. P., and Freedman, S. S. *The Relation of the Household Dusts to Asthma in Childhood.* RHODE ISLAND MEDICAL JOURNAL 22:42, March, 1939.

[2] O'Keefe, Edward S. *An Analysis of Three Hundred Cases of Asthma in Children.* New England Journal of Medicine 214:62, January 9, 1936.

[3] Chobot, R. *Asthma in Children.* American J. Dis. Child. 45:25, January, 1933.

Fifteen patients had eczema either present or had had it in the past. Only three had had colic or vomiting in early infancy. There were twenty-five boys and thirteen girls. Among the seven most severe cases, five were boys and two were girls.

It has been stated that skin tests are not worth doing on babies. I cannot agree with this, as it seems to me that the tests were of definite help in planning treatment. The accompanying table shows the first eighteen scratch tests on seventeen babies under one year of age with asthma. The relation of the skin tests to the clinical sensitivity in some of the cases will be shown later.

The most interesting and instructive cases were the seven of greatest severity. These patients, whose clinical sensitivities and skin tests are shown in tables 5, 6, 7, 8, 9, 10, and 11, were in five cases made wheezy by many different etiological agents, including inhalants, foods, and respiratory infections. Only those clinical sensitivities which were definitely demonstrated are mentioned. It seems evident that more sensitivities would have been recognized if a greater effort could have been made in studying the patients.

It is interesting to note that one of these babies was repeatedly relieved by sulfadiazine, and two others were completely relieved for long periods of time by treatment in the hospital with penicillin intramuscularly. This must have been due to the lessening of superimposed infection.

NOTES ON CASES

Table 5

J. B.

His asthma began at three weeks of age. He was seen at six months of age when he was wheezy most of the time.

SCRATCH TESTS

Years of age	Eight months
Cat	†
Dust	†
Wheat	†
Egg	†
Aspergillus	†
Spinach	†
Potatoes	†

He was made more wheezy by playing in the living room, lying on the bed or sofa, and by eating egg, potato, spinach or wheat.

Results: After one year of treatment he was improved. After seven years he still has "occasional asthmatic attacks."

The patient began to snuffle and have noisy breathing at three weeks of age. At three months

Table 4

THE FIRST EIGHTEEN TESTS
ON ASTHMATIC BABIES UNDER ONE YEAR OF AGE

	Cat	Dog	Rabbit	Horse	Feather	Orris	Cotton	Kapok	Dust	Grass	Ragweed	Wheat	Milk	Egg	Aspergillus	Alternaria	Hormodendron	Penicillium
J. A.																†	†	
S. B.															††	††	†	
J. B.	†								†			†		†				
D. B.										†							†	
A. C.				†	†	†	†	†						††			††	
R. C.				†††				†			††			†††		†		
L. D.													††	††				
D. D.							†							††	††		†	†
L. E.															††			
S. H.						†										†		†
D. K.																		
D. L.				†				†						†				
V. N.	All negative																	
B. O.	All negative																	
E. S.																††		
G. S.													†					†
L. S.																†		

of age this was so pronounced that he was studied and pronounced a case of Thymic Stridor. X-ray treatment did not change the symptoms.

At six months of age he was obviously dyspenic and a diagnosis of asthma was made. After his room was cleaned up he was very much better. It was noticed that he wheezed when taken into the living room or when put on his mother's bed, and also ingestion of wheat, egg, spinach or potato made him wheezy. If he was kept in his own room or out of doors and if these foods were avoided he wheezed very little. In this case the skin tests and the known clinical sensitivities coincided very closely.

Table 6

A. C.

His asthma began at seven months. He was seen at eight months when he was wheezy most of the time.

SCRATCH TESTS

Year of age	9/12	1 year
Horse		†
Dust	†—	0
Ragweed	†—	0
Egg	†††	††
Feathers	0	†
Orris		†
Cottonseed		†—
Kapok		†—
Hormodendron		††
Beef	†	
Chicken	†—	
Rice		†
Peanut		††
Mustard		†††
Silk		†
Pyrethrum		†
Human		†

He was made more wheezy by colds, and was distinctly better without milk.

Results: He had moderate asthma frequently until over a year old. After treatment with Penicillin he had no asthma for three months, and now at 2 years of age has had very little wheezing for 6 months.

In this case, as shown in table 6, there were many positive tests. He was wheezy all the time with severe exacerbations. He was put on a program of avoidance and injections without much change except that he was better without milk.

He was put in the hospital three times, and the third time was given penicillin intramuscularly for a week. This relieved him completely and he has been almost entirely well for six months.

I believe that this baby was sensitive to many inhalants and foods although we could not demonstrate this. The great benefit from hospitalization and penicillin seemed to be clearly due to the clearing up of superimposed infection.

Table 7

L. D.

Her asthma began at 7 months. She was seen at 8 months when she had been slightly wheezy for 3 weeks and in severe dyspnea for 3 days.

SCRATCH TESTS

Years of age	8/12	1 8/12	8	5	12
Cat	0		†	†	††
Dog	0		†	†	†††
Horse			†	0	†—
Feather			0	0	†—
Kapok					†††
House dust			0		
Timothy	†—		0	0	†—
Wheat			0	†—	0
Milk	††	††	0	0	†
Egg	††	††	0	0	†
Rice			0	††	††
Salmon			0	0	†
Tomato	0				†
Hickory					††

She was made wheezy by colds, milk, cat and the dust of her own house.

Results: She improved very slowly and now, at 23 years of age, has occasional slight wheezing when she has a cold.

This patient in infancy was a severe case. It was demonstrated that she was clinically sensitive to milk, cat, and the dust of her own house, and much of her trouble was obviously brought on by colds.

Her improvement on a program of avoidance and injections was very slow over a period of years. This delay seemed to be at least partly due to poor success in eliminating dog dander and other dusts, and in getting co-operation in dieting.

Her final improvement seems to be the natural one which frequently take place as these children reach maturity.

Table 8

C. F.

Her asthma began at 14 months. She was seen at 16 months when she had a persistent cough with occasional wheezing.

SCRATCH TESTS

Years of age	1 4/12	2	3 8/12
Cat	††		††††
Dog	†††		††
Horse	0		††
Feathers	0		†
Dusts	†		†
Grass	0		†
Egg	†††		††

continued on next page

Aspergillus	†	†	0
Beef	†††	†††	†
Chicken	††	0	0
Carrots	0	†	0
Lima Beans	0	0	†
Spinach	0	†	0
String Beans	0	†	0
Potato	†	†	†—
Corn	††	†	†††
Peanut	0	0	†
Pork	††	0	0
Almond		†	0
Mustard			†††

She was made wheezy by cat as well as by tomato, peas, string beans, spinach and respiratory infections.

Results: She did badly until at 6 years of age. Penicillin was given. During the last 8 months she has had 2 courses of Penicillin and each time has been well for 4 months after.

This baby is a case where the tests and the clinical sensitivities were by no means the same. She was clinically sensitive to tomato and peas which gave entirely negative tests, to string beans and spinach which each gave a faintly positive test once only, and to cat which gave a good positive skin test.

Here infection played a very important part. Her greatest improvement was evidently from the two courses of penicillin in the hospital.

Table 9

J. M.

His asthma began at 23 months. He was seen then and his wheezing was almost continuous.

SCRATCH TESTS

Years of age	1 11/12	4	7	8	11	14	23
Grass	0	0	0	0	0	††	†
Ragweed	0	0	†	††	†	†	0
Dog	††	0	††	††	††	†	††
Cat		0	††	†	††		0
Horse			†††	††	††		0
Rabbit			0	0	0		0
Feathers			0	0	0	†	†
Dust				††	††	†	†
Egg		††	††	†††	†	†††	0
Orris		†	0	†	0	†††	0
Own pillow						0	
Spinach						†	
Potato		††					
Peas		††					

He was made wheezy by dog, dust of his own cellar, eggs, spinach and sweet potato.

Results: He improved slowly and now at 23 years of age has wheezed for only two days during the last year. As an infant he wheezed all the time with period of moderate severity. His early tests were significant in that he was definitely made wheezy by a dog, and by eating egg or spinach. Treatment by avoidance and by injection accomplished very little at first, but he gradually improved and at six years of age could go to school most of the time, and now at twenty-three years of age he is practically well.

It seems probable that he was allergic to many things that we could not demonstrate.

Table 10

M. M.

His asthma began at 7 months. He was seen at 13 months when he was wheezing all the time with periods of severe dyspnea.

SCRATCH TESTS

Years of age	1 1/12	2 1/2	7
Horse	†—	††	†—
Feathers	†	0	†—
Orris	†—	0	0
Cottonseed	†	0	0
Dust	†	†	††
Ragweed	†—	††	†††
Wheat	††††	†††	†† ††
Egg	†††	††	†
Alternaria	0	0	††
Beef	0	0	†
Potato	†	†	†
Rice	††	††	†
Cornmeal	†	†	††
Oats	††	††	††
Rye		0	††
Peanut	†††		0
Mustard			†

He was made more wheezy by house dust, ragweed, prunes, beef liver, orange, probably by wheat, and also by respiratory infections. Beginning in his third year he was worse in the ragweed season.

Results: He improved only slightly and still wheezes some every day at 10 years of age. Otherwise his health is fair. As an infant he wheezed all the time with exacerbations. Treatment was notably unsuccessful, due partly to very poor family co-operation. He was known to be clinically sensitive to house dust, ragweed and several foods.

Table 11

A. T.

His asthma began at 4 months, and became severe at 14 months when he was wheezy most of the time. He was seen at 22 months.

SCRATCH TESTS

Years of age	1 10/12	4
Horse	††††	††††
Feather	††††	††
Cotton	0	†—
Kapok	0	††
Dust	0	††
Grass	0	†††

Ragweed	0	†
Wheat	0	†
Milk	††	††
Egg	††††	†††
Alternaria	0	†—
Hormodendron	0	†—
Many foods	†	†

He was made more wheezy by respiratory infections. He was better without milk and better without orange juice. Beginning in his third year he was distinctly worse in the grass season.

Results: At 6 years of age he has had moderate attacks in the last year and has been a little wheezy occasionally between attacks.

As a baby he was a very severe asthmatic, coughing, snuffling, and wheezing all the time. He improved gradually and was better without orange juice and also better without milk. Beginning in his third spring he was definitely worse in June and early July, probably on account of grass pollen. Sulfadiazine has been useful at times.

On a program of avoidance and desensitization he has slowly improved. During the last year, at 6 years of age, he has had two moderate attacks of asthma and has wheezed a little several other times.

It is evident that in these severe cases there were many sensitivities. The sensitivities listed were those in which the allergen was shown by trial to produce wheezing. It is obvious that there were many others which were not so demonstrated, as it was often by accident or by error that the demonstration took place.

It seems probable that babies with asthma have in general many sensitivities which are not obvious in the milder cases. This would adequately explain the fact that we get only moderate improvement by eliminating one or more known causes.

The action of infections is important at this age. Whether the attack is induced by an infection or a non-bacterial allergen, it seems evident that the bronchial reaction is often increased and prolonged by superimposed infection. Two of the seven severe cases described, who were wheezing badly week after week, gained a long continued relief by the use of penicillin in the hospital.

Among the babies we find many serious cases. If not treated promptly, they often get rapidly worse and become the most severe cases of chronic asthma. They need very carefully study and prolonged and painstaking treatment.

DIAGNOSIS

There is a characteristic of asthma in infancy which often makes us slow in making the diagnosis. The wheezing, prolonged expiration and the musical rales, which are typical of asthma in later life, are often absent in infancy. Instead there is a noisy breathing with only moderate dyspnea, and with the stethoscope nothing is heard but loud tracheal rales. This noisy breathing which does not seem to be typical of anything may lead us away from the diagnosis of asthma.

The diagnosis is made, partly by the demonstration of allergy by history, skin tests, and blood eosinophilia, and partly by ruling out other conditions which could cause dyspnea.

Among the 38 cases reviewed, two had been diagnosed thymic stridor and one hypertrophied adenoids, and undoubtedly these diagnoses were incorrect.

RESULTS OF TREATMENT

It is recognized that children with asthma do better than adults. In the Rhode Island Hospital allergy clinic, Dr. Freedman and I found that 61 per cent of these patients were either entirely relieved or nearly so, and that a total of 87 per cent were definitely helped.[1] This was true one year after admission, and the results were still better three years later.

Table 12 shows the results after one year of treatment of the babies under two years. The number of cases is so small that a statistical analysis is of limited value. However, the figure of only 43 per cent of the known cases, which were entirely or almost entirely relieved, is suggestive of the difficulty of treatment at this age. Most of the others however were definitely helped, and it must also be taken into consideration that without treatment some of these patients would surely have developed a much more serious type of asthma.

Table 12

Results of Treatment after One Year

Perfect	4
Almost perfect	9
Fair and poor	17
Not known	8

One patient died three years later. Her asthma became worse but the cause and circumstances of death are not known.

SUMMARY AND CONCLUSIONS

The purpose of this paper is to present the idea that each infant with asthma has many sensitivities both inhalant and food. This is readily demonstrable in most of the severe cases and seems to fit in with the course of the milder ones.

It seems probable that infection acts to increase the irritability of the bronchi, and thus initiates an attack in an individual who is already in an abnormal state due to his allergy. An infection may also be imposed on an already edematous bronchial mucus membrane and prolong an attack of asthma.

continued on next page

The picture of the disease as shown by these records gives no evidence in favor of bacterial allergy as a sole cause of asthma in any one case.

The frequency, severity and certain other characteristics of asthma in infancy are briefly discussed.

DISCUSSION

STANLEY S. FREEDMAN, M.D.

Associate Physician, Department of Pediatrics, R. I. Hospital

ASTHMA in childhood is a real challenge and deserves our best efforts, not only because of the great suffering it produces but also because of the large number of children afflicted. Dr. Robert Cooke of New York states in his 1947 text book on clinical allergy, that 3½% of the population has bronchial asthma. If the childhood population is 1/5 of the total, then we have in this state alone about 3,000 children who have asthma.

I would like to go back a few years and trace the history of this amazing new field in medicine as it ties with Dr. Buffum's work.

We all know that allergy was born at the end of the last century with the introduction of diphtheria antitoxin. The use of horse serum created a situation which has heretofore never been known to medicine, namely serum sickness and anaphylactic death. So urgent was the use of diphtheria antitoxin at that time that its continued administration could not be interrupted no matter what the consequences. As a result of this situation an extensive amount of studies was undertaken mostly by immunologists. These studies were confined to the nature of serum sickness and anaphylaxis in man and experimental anaphylaxis in animals and a large mount of fundamental knowledge was thus obtained.

From about 1915 on a new crop of investigators appeared. These investigators began the study of clinical allergy in real earnest. They are now referred to as pioneers. I would like to mention the names of some of these men: Cook, of the Presbyterian Hospital in New York; Rackemann of the Massachusetts General Hospital; Walzer of the Brooklyn Jewish Hospital; Rowe of California; Alexander of St. Louis; Feinberg of the University of Illinois; Vaughn of Richmond. These men studied, analyzed, classified and observed thousands of patients over many years and their conclusions and observations together with the experimental work mentioned above formed the backbone of today's knowledge.

Precisely in the same manner Dr. Buffum has analyzed and studied his cases. His conclusions are not only sound, they should be taken as guides in the evaluation of any one given case. Most impressive is his statement of the multiplicity of sensitivities, especially in the severe cases. The greater the effort, the greater the possibility of discovering new factors.

We must never minimize the importance of house dust and its component elements, bearing in mind always that it is the organic nitrogenous matter in the dust which provokes sensitization. At the same time we must not rely entirely on house dust for by so doing the opportunities for uncovering additional factors will be lost. It is the judicious selection of the most likely offenders and their proper management which will give the best results.

I think we should not be too hasty with the use of penicillin, unless there is present an infection which in itself indicates its use. Penicillin is a moderate sensitizer and one should not subject a child who has an allergic constitution to unnecessary sensitizing substances.

I would like to call your attention to the urgent need of additional institutional facilities for allergic children. Our regular hospital facilities do not answer that need. A child whose asthma can not be controlled at home may need a change of environment from a few days to a few weeks. As soon as that child goes to the hospital and receives the same medication which at home gave no relief he becomes asthma free in a most spectacular manner. At this time the hospital is no longer a good place for him. In fact he is so well that he is in the way. Often upon his arrival home his asthma promptly returns.

What these children need is a hospital annex or a community asthma home located preferably in a suburb away from the hospital excitement and resembling a convalescent home. The annex should be so constructed and so furnished as to contain

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COMMON SKIN DISEASES AND THEIR TREATMENT*

WILLIAM D. WOLFE, M.D.

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A CAREFUL ANALYSIS of the dermatologic problems confronting the general practitioner will reveal that the overwhelming proportion fall into several distinct groups, all of which are easily diagnosed and quite amenable to treatment. It is my intention to analyze these groups and to discuss methods of diagnosis and therapy which are readily available to the general practitioner.

HISTORY AND EXAMINATION

It is generally agreed that a lengthy or detailed history is unnecessary when dealing with the common skin diseases. As a matter of fact, the history is frequently misleading for the patient is apt to place undue emphasis on irrelevant events. The skin is laid out before us very much as the pages of an open book, and we have merely to observe and interpret. The best and least time consuming method of procedure is to ask the patient a few leading questions (duration and location of the eruption), then conduct the examination, following which specific questions may be asked in order to clear up any obscure points remaining in the examiner's mind.

Unless the skin disorder is quite obvious at first glance it is of the greatest importance to examine the entire body. Many patients, either through ignorance or reticence, will fail to expose enough of their cutaneous envelope, as a result of which many important diagnosis are frequently overlooked. For example, it has been my experience that patients with scabies will often be unaware of the fact that their body shows lesions typical of that disease.

It is essential that the examination be performed in a room with good lighting, preferably in daylight. The roseola of secondary syphilis or the nits of pediculosis pubis are easily overlooked in the absence of proper lighting.

The following diseases or groups of diseases are those most frequently encountered by the general practitioner.

SCABIES

Scabies is without doubt the most frequently misdiagnosed common skin disease despite the fact that in the vast majority of cases the diagnosis is quite simple. The incidence of this disease has shown a marked increase in recent years since many soldiers, upon returning home, have infected their families. The diagnosis is generally overlooked because (1) the disease is not suspected and (2) not enough of the body is examined. A diagnosis of scabies is made, not on the type of lesion, but rather on the distribution of the eruption. The sites of predelection are the finger webs, flexor aspect of the wrists, anterior axillary folds, elbows, umbilicus, buttocks and penis. In women the nipples are frequently involved. Upon questioning one will generally elicit the information that the eruption is very itchy at night and that other members of the family are involved. With a little practice the acarus scabei or its ova may be demonstrated microscopically by examining the roof of a fresh vesicle after mounting it on a slide and adding a drop of 10% NaOH.

Treatment. It is important that all affected members of the family be treated simultaneously in order to prevent subsequent cross-infection. The old time honored remedy of 10% sulphur ointment massaged into the entire body twice daily for 3 days is still effective even though it is rather messy and may produce a sulfur dermatitis. It has been my experience that a combination of 5% sulfur and 5% balsam peru in an ointment base is efficient and rarely irritates. During the past few years benzyl benzoate 25-33% in an emulsion has become quite popular in that it is a cleaner method of therapy and more rapid in its results. A double application of this preparation allowed to remain on the skin overnight is generally sufficient to eradicate the disease, but it is a wise safety measure to repeat this treatment 24 hours later. Following antiscabetic therapy all bedclothes and wearing apparel should be thoroughly washed or cleansed. Any residual skin irritation may be controlled by compound calamine lotion or cold cream with ½% phenol.

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* Presented before the Rhode Island Medical Society at its 136th Annual Meeting, at Providence, May 15, 1947.

INFECTIONS

Impetigo contagiosa and its variants are among the most common skin diseases seen by the general practitioner. The typical eruption of impetigo will present no diagnostic difficulties. The primary flaccid superficial vesicle produced by this disease ruptures quickly and exudes considerable serum which dries to produce a thick, honey colored crust. Because of the superficial nature of the disease process healing is accomplished without the production of scars although temporary pigmentation is frequently observed. When the disease affects the lower extremities it shows a distinct tendency toward deeper invasion of the tissues and often heals with scar formation. This type of infection is known as ecthyma and is most often seen in children, the subjects of poor hygiene.

Although impetigo is generally an innocuous condition it must be treated carefully because of its contagiousness. Then, too, if the bearded area is involved there may be extension of the process into the follicles to produce either a folliculitis or a stubborn treatment-resistant sycosis vulgaris.

It is well to remember that impetigo of the scalp and neck is frequently associated with pediculosis capitis while a generalized impetigo is often due to an antecedent scabetic infection. In these cases the underlying parasitic disease must first be treated.

Treatment. The most essential step in the treatment of infections of the skin is the removal of the crusts. This can usually be accomplished by bathing with warm water or oil until the crusts are softened. Following this step a local antiseptic is applied, and one may choose from many of these agents. 5% ammoniated mercury ointment is one of the oldest and most popular antiseptic ointments. It should be applied lightly not only to the individual lesions but also to the normal skin immediately surrounding them in order to prevent autoinoculation. The sulfonamide ointments are frequently used even though many investigators feel that there is a distinct danger in sensitizing the patient to the drug. Penicillin ointment (1000 u/gm.) is a very efficient remedy and will often produce a favorable result in a comparatively short period of time. Commercial tinctures such as metaphen, mercurochrome and merthiolate may likewise be employed. It must be remembered that if iodine has been used mercurials are contraindicated since their combination will produce a severe dermatitis.

In widespread impetiginous eruptions small doses of ultra violet are quite helpful. It is occasionally but rarely necessary to administer oral doses of sulfonamides or penicillin injections.

For sycosis vulgaris good results are frequently obtained through the use of Squibb's antiseptic ointment (Quinolor).

ACNE VULGARIS

This disease presents no diagnostic problem. It occurs chiefly in adolescents and is characterized by comedones, papules, and papulo-pustules superimposed on an oily skin. The face, chest and back are most often involved and there is frequently a concomitant, oily scale in the scalp. The treatment of this condition constitutes a challenge which should not be evaded by the physician. If patients with this disorder are dismissed lightly with a pat on the shoulder and the inaccurate prognostication that they will outgrow the disease the ultimate result is often a severe cosmetic defect in the form of pitted scarring together with a marked inferiority complex.

Treatment. There are few cases of acne vulgaris which cannot be helped considerably by means of proper general and local therapy. Dietary instructions should be given the patient and while the diet need not be rigid it should not contain chocolate, fried foods, and excessive amounts of carbohydrates. Constipation must be combatted and a moderate amount of outdoor exercise prescribed. Foci of infection should be searched for and eliminated. Secondary anemia, when present, should likewise be corrected. In the vast majority of cases it will be found that the acne patient enjoys perfect health and no general therapeutic measures are necessary. In these cases the greatest dependence is placed upon local therapy, the object of which is to produce a moderate degree of dryness in a skin which presents an overabundance of oil. The following routine is successful in most cases.

Before retiring the affected areas are washed thoroughly with soap and water.

After the skin is dried a sulfur shake lotion is applied (either Kummerfeld lotion or Lotio alba may be used for this purpose) and allowed to remain on the skin overnight, the remnants washed off the following morning. Unless the lotion produces uncomfortable dryness of the skin it is to be used each night. If the skin is not dried sufficiently the strength of the lotion may be increased by the addition of resorcin ½-3% and beta-napthal ⅛-2%.

It is well to instruct the patient that comedones and pustular lesions should not be expressed unless only a minute amount of pressure is required. Undue squeezing and picking will aggravate this condition and will frequently lead to excessive scarring.

If an ultra violet lamp is available, suberythema doses once or twice weekly are frequently beneficial. The patient should be advised that at least three months of "drying treatment" are necessary. Should there not be noticeable improvement after that period of time a Dermatologist should be consulted. Superficial x-ray therapy in the hands

of the dermatologist often produces amazingly good results in even the most disfiguring and obstinate cases of acne vulgaris.

In passing, it has been found that injections of hormones, vaccines, penicillin and the sulfa drugs are of no avail in the therapy of acne vulgaris.

FUNGUS DISEASES

The mycotic diseases discussed in this paper will be limited to those of the superficial variety, which involve the feet, body and scalp.

DERMATOPHYTOSIS OF FEET

Dermatophytosis of the feet is seen so commonly in this country that most patients with a mild degree of involvement do not seek medical advice. Upon examination one may discern a slight amount of maceration and scaling between the toes, most commonly in the 4th interspace. When, because of increased perspiration and friction with attendant loss of local resistance on the part of the tissues, the process becomes more acute, the eruption presents a different picture. There will be vesiculation, exudation, crusting and edema—the cardinal signs of an acute eczematous eruption. A secondary allergic reaction known as a dermatophytid may appear about the fingers during this acute stage.

The diagnosis of dermatophytosis may be confirmed by examination of material from the eruption. Mycelial threads and occasionally spores may be demonstrated microscopically after the tissue is allowed to dissolve in 10% NaOH.

Treatment of ringworm of the feet is dependent on the stage of the eruption. If the process is acute, soaks of Burows solution, normal saline or boric acid should be used. If there is secondary infection soaks of 1-4000 potassium permanganate solution will prove very efficient in combatting the pustular element. After the acute process subsides, fungicidal and keratolytic agents may be employed. Whitfield's ointment (½ strength), 5% salicylic acid in alcohol or Castellani's paint are useful in the chronic stages. Of late, much attention has been devoted to the use of higher fatty acids and their salts. The great advantage of these newer preparations, (proprionic and undecylenic acids), is that they may be employed in practically any stage of the condition without danger of producing a dermatitis.

TINEA CORPORIS

Of less common occurrence is fungus disease of the body. As a rule tinea circinata presents a well defined, annular eruption with vesicular margins and a distinct tendency to clear in the centre while extending peripherally. The diagnosis is confirmed by the microscopic demonstration of mycelial threads in tissue obtained by scraping the outer vesicular margin of the lesion. Treatment is not difficult and consists of application of a keratolytic agent such as 5% salicylic acid ointment until the superficial epidermal layers have exfoliated, in this manner ridding the skin of the fungus elements.

Tinea versicolor presents a somewhat different picture. This form of fungus involvement produces no reaction on the part of the skin but merely layers itself as a thin film on its surface. Individuals with moist skins are usually subject to this condition and the covered areas of the body are affected to the greatest degree. The diagnosis is quickly established by the clinical appearance—light tan mottled areas which on close inspection appear to resemble thin cigarette paper plastered on the skin. A scraping will quickly reveal numerous mycelial and spore elements. Tinea versicolor may be cured through the local application of a saturated solution of sodium hyposulphite, but there is a distinct tendency toward recurrence especially during the warm seasons of the year.

TINEA CAPITIS

Tinea infection of the scalp has within recent years become a formidable problem in every large city. This condition affects children until the age of puberty when a natural immunity develops. This immunity may be explained on the basis of change in the oily scalp secretion with a resultant lowering of the PH. The disease is transmitted from person to person by body contact, exchange of caps, by unclean clippers in barber shops and by upholstered seat backs in moving picture houses.

The diagnosis of tinea capitis is made by the classic appearance of circular areas of partial alopecia in the scalp. The affected portion of the scalp may or may not show gross inflammation, depending upon the type of fungus responsible for the disease. Under Wood filter the areas invaded by tinea reveal themselves by the presence of brilliant green fluorescence. Examination of the affected hairs microscopically will reveal myriads of closely packed spores either around or within the hair shaft.

Tinea capitis is commonly produced by either human or animal type of fungus and the distinction in most cases may be made only by cultural characteristics. The differential diagnosis should be made, however, since the animal type will respond to local applications of 10% ammoniated mercury ointment or to the newer undecylenic and proprionic acid fungicidal agents, while the human form will remain quite resistant to local therapy. The latter type will often require temporary epilation through the use of x-ray. Under this method of therapy local applications are used during the three month period during which the scalp is devoid of hair.

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PITYRIASIS ROSEA

Pityriasis Rosea is a skin disease of unknown etiology which is most prone to occur in the Spring and the Fall. The process usually develops first with a solitary lesion on some portion of the trunk, (the so called herald plaque), followed one or two days later by a multitude of smaller lesions most pronounced about the thorax and abdomen. The individual lesion at the onset is pea to dime sized, slightly raised and erythematous, oval in contour, with its long axis parallel with the lines of cleavage in the skin. As the lesion grows older it becomes slightly larger and shows a tendency to scale in the center. Itching may or may not be a prominent symptom depending on the severity of the condition and the nervous threshold of the patient.

The full blown eruption may be confused only with secondary syphilis but as a rule the differential diagnosis is not difficult. It is undoubtedly a good safety measure for a serologic test to be performed in every case of suspected Pityriasis Rosea. Occasionally the primary or herald plaque may be confused with tinea corporis, but the absence of mycelial threads when the scraping is examined microscopically together with the subsequent appearance of a multitude of lesions will confirm the diagnosis.

The patient is to be reassured that the condition is not contagious, will leave no scars and will not recur. It is a self-limited condition, lasting about 6-10 weeks without therapy. However, if proper treatment is prescribed the course may be abbreviated to 10-14 days.

Treatment. Any method of therapy which produces a mild exfoliation of the epidermis is indicated. Generalized ultraviolet radiation in suberythema doses every second day is a clean and effective method of attaining this end. If itching is a prominent symptom calamine liniment with ½-1% phenol and ¼-½% menthol is helpful. 3% resorcin may be added to the mixture in order to promote exfoliation. It is best to limit the use of soap on the affected areas and in very severe cases colloid baths may be prescribed.

CONTACT DERMATITIS

Skin eruptions due to external contacts may be produced by substances of animal, mineral or vegetable origin. As a rule the diagnosis can be made rather readily on the basis of an inflammatory skin eruption characteristically involving the exposed areas of the body and composed of vesicles and bullae arising on an erythematous base. On the other hand the etiologic agent responsible for the outbreak may be determined only with great difficulty. It is often necessary to take a painstakingly accurate history, which will include the analysis of all contacts prior to the development of the eruption.

Dermatitis venenata due to plants usually presents an acute vesicular eruption arising primarily on the exposed portions of the body. One frequently observes a tendency toward linear arrangement of the vesicles. The commonest plant allergens are poison ivy, poison oak, and primrose.

Dermatitis due to cosmetics is diagnosed chiefly by the distribution of the eruption. Deodorants, lipstick and perfumes produce an eruption in sensitized individuals at the site of their application. Nail polish dermatitis, on the other hand, appears on the eyelids, cheeks and neck as erythematous, scaly, intensely pruritic, ill-defined patches. Dermatitis due to hair dye or lacquer first makes its appearance about the ears, eyelids, forehead and neck. As a rule the scalp is not involved because of its great natural resistance to chemical insult.

Dermatitis of occupational origin is of great importance because of its frequent occurrence and disabling tendency. The agents responsible for this type of eruption may be placed in two categories (1)Those which are primary irritants and will, therefore, produce an eruption in every individual (strong acids and alkalies) and (2) Those which will sensitize certain individuals following a primary exposure (oils, dyes). As a rule it is not difficult to ascertain the cause of the eruption when due to a primary irritant, but the reverse is true when the sensitizing agents are considered. In these cases the application of suspected substances to the skin by means of the patch test is of considerable importance. Since occupational dermatoses have been made compensable by appropriate legislation in many states it is important whenever possible, to determine the exact etiology in a dermatitis of that nature.

Treatment of Dermatitis. Removal of the offending agent is generally followed by rapid improvement of the eruption. Where cosmetic dermatitis is suspected all cosmetics should be removed until the causative allergen is found. When occupational dermatitis is diagnosed the patient, during his period of treatment, should either cease work entirely or change to another type of work, depending upon the severity of the eruption.

Therapy in all cases of dermatitis should be of the soothing variety. In the acute stage of the disease lukewarm soaks, compresses or saturations must be depended upon. Saturated solutions of boric acid, magnesium sulfate, and (1-30) Burow's solution are most commonly used in this stage. When the process begins to dry a light application of cold cream or boric acid ointment will prevent painful fissuring and undue tightness of the skin. The patient should abstain from the use of soap on the affected areas, but a sulfonated oil may be employed for cleansing purposes when necessary in the chronic stages.

Prophylactic therapy for poison ivy dermatitis by means of rhus antigen injection or ingestion is occasionally of some benefit. During the acute severe attack of poison ivy or poison oak cautious injection of the antigen has been of some value in my hands.

Whenever possible in the case of occupational dermatitis, the patient's occupation should be changed, for desensitization to the allergen cannot be accomplished in the light of our present knowledge.

ALOPECIA AREATA

This common skin condition of unknown etiology may affect any hirsute region but is seen most commonly in the scalp where an asymptomatic patch of complete baldness is observed. As a rule it grows slowly larger as the hairs at its periphery loosen and fall. Other similar areas may appear elsewhere and because of the cosmetic appearance become a source of great embarrassment and concern. Occasionally, but fortunately rarely, the condition progresses to involve the entire body.

Although the cause of alopecia areata is unknown it is thought to be associated with nervous influences for it frequently follows a "nervous shock" and usually affects high strung individuals. The diagnosis is made readily by the normal, smooth appearance of the affected areas. Because of the lack of inflammation and scaling it may be differentiated from tinea capitis. Other points of differentiation are that tinea capitis does not affect adults and shows a green fluorescence under Wood filter.

The prognosis is generally good except in elderly individuals and in cases of total alopecia. The hair usually regrows after a period of several months.

Treatment. Since the condition is apparently of nervous origin, therapy should be directed to avoidance of stress and strain along with the procurement by the patient of more rest and relaxation. Local therapy should be of the stimulating nature. Application of phenol-alcohol to the area of alopecia along with an exposure to ultra violet once weekly will hasten the regrowth of hair. When ultra violet radiation is employed it is to be remembered that the scalp will readily tolerate five times the dose given to other areas of the body. During therapy, therefore, the forehead and neck must be protected against undue exposure.

CONCLUSIONS AND SUMMARY

If the general practitioner is to practice good dermatologic medicine a few important, basic principles must be followed.

1. A careful examination should be performed in a well lighted room, and the entire body examined when the diagnosis is not immediately obvious.

2. The physician should acquaint himself with a few simple remedies, learning what may be expected of them when they are properly used. He should not use unknown proprietary medication at the recommendation of a detail man, until the value of such medication is thoroughly established.

3. The patient should be instructed carefully concerning the use of medication, its method of application and removal.

4. Skin diseases should never be overtreated. If in doubt, soothing medication is never harmful while overzealous use of strong medicaments will often produce a disastrous reaction.

5. The overwhelming majority of skin diseases are not difficult to diagnose and will respond readily to therapeutic measures available to the general practitioner.

11 E. Chase Street

CHARACTERISTICS OF ASTHMA IN INFANCY

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a minimum of organic dust. In such a place a child could regain his lost weight and there he could be relieved completely of his residual asthma. We often see children whose asthma could not be controlled at home, but who are promptly relieved upon transfer to Lakeside Preventorium. It seems that a change in residence interrupts the mechanics responsible for the continuation of a given attack.

The filtration units which some of our hospitals have are not satisfactory. They are noisy, the room temperature can not be controlled properly and every time the door is opened suction draws in atmospheric air from the corridors and adjacent rooms. The most logical method of treating the acute attack in a child when home treatment has failed is to hospitalize him for two or three days in a clean, quiet room followed by a longer period of residence in a convalescent annex or unit such as described above so that by the time he goes home, he will have a reasonable chance to remain symptom free at least for the time being.

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PSYCHOSES WITH TRICHINOSIS*

A Review of the Literature and the Report of a Case

WALTER E. CAMPBELL, M.D.

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TRICHINOSIS is a generalized systemic disease caused by the parasite trichinella spiralis. According to autopsy reports, about 20% of the adult population of this country have been infested by the parasite. However, only a portion of these have exhibited the disease clinically. The disease is divided into three stages:—(1) The stage of invasion, (2) the stage of migration, (3) the stage of encystment. The first stage, lasting two or three days is initiated by the passage of the larvae through the intestinal walls setting up a severe irritation, causing symptoms of nausea, vomiting and diarrhea, and in general resembles acute food poisoning. The second stage is characterized by the dissemination of the larvae throughout the body by way of the blood stream. Chiefly the striated muscles are invaded, but the heart and brain may also be affected. This is accompanied by fever and varied and protean symptoms. The third stage of encystment takes place when the larvae are encapsulated in the muscle tissues.

It is during the stage of migration that the central nervous system is involved. This is not as uncommon as is generally believed. Merritt and Rosenbaum[1] found that 10% of the cases diagnosed as trichinosis at Boston City Hospital exhibited some involvement of the nervous system. However, up until 1936 only thirteen cases of psychoses associated with trichinosis were reported in the literature. Merritt and Rosenbaum in 1936[1], Most and Abeles in 1937[2], and Evers in 1939[3] reviewed these same thirteen cases and presented additional cases. A review of the English literature since 1936 has revealed only six additional cases of trichinosis with cerebral involvement.[1,2,4,5,6] In two cases the reason for hospitalization was an acute psychosis and they were direct admissions to psychiatric hospitals. The mental picture exhibited by these patients is that of an organic psychosis of the toxic hallucinatory type. Neurologically headache, stiff neck, muscular weakness, diminished or absent reflexes, hemiplegia or paraplegia were noted commonly. The diagnosis of trichinosis was established by the history of pork ingestion, a typhoid like fever, eosinophilia, usually of a high grade, by the skin test and by biopsy of muscle.[7,8,9,10] It was rare that all criteria were positive in any one case.

When this disease involves the nervous system it may simulate (1) Polyneuritis, (2) Acute anterior poliomyelitis, (3) Encephalomyelitis, (4) Meningitis, (5) Dermatomyositis, (6) Periarteritis nodosa. In trichinosis of the central nervous system the spinal fluid is usually normal, helping to rule out poliomyelitis, encephalitis, and meningitis. Polyneuritis may be ruled out by laboratory tests, as may be dermatomyositis. Periarteritis nodosa may be ruled out by skin tests and biopsy.

The pathological changes in the nervous system are those of a non-suppurative meningo-encephalitis caused by the presence of the larvae of trichinella spiralis in the brain, chiefly in the cortical and subcortical layers, and also by non-specific changes due to toxic products of the larvae and decomposed muscle tissue. The latter changes are looked upon as being more dangerous and more common.[2]

The prognosis in these cases is not good. In Merritt & Rosenbaum's series, six out of thirteen died and two had residual neurological damage.[1] In the six cases reported since 1936, there was a mortality of 50%. The treatment of this disease is largely symptomatic and resembles much the care of the typhoid fever patient.

Report of a Case

The patient, A. H., a thirty-year old white married male of English extraction was well up until August 29, 1947, when he became nauseated, was unable to eat and had a diarrhea that lasted for three days and required treatment with bismuth and paregoric. During the two weeks prior to the onset of his illness he had eaten in a restaurant in the lower waterfront district of Providence while his wife was in the hospital undergoing surgery. His diet consisted chiefly of meatballs and spaghetti. He recalled eating no pork or sausage.

* Presented at a meeting of the Rhode Island Society for Neurology and Psychiatry, at Providence, October 20, 1947.

Following the diarrhea he developed severe headache and stiff neck, and on September 2nd it was found that he had a fever of 102.8°. He then had generalized pains in the chest, and weakness of his left leg. He became progressively worse until September 9th, when he developed severe backache, felt more feverish and became mentally confused. He stood in one position staring straight ahead for periods up to one hour. He chewed paper and sticks about the house and voided on the floor.

He was admitted to the Contagious Service of Chapin Hospital on September 11, 1947, with a tentative diagnosis of poliomyelitis. Because of his confused, uncooperative behavior he was seen by the neuro-psychiatric department on September 12th and transferred to that department on September 13th. At that time he appeared well nourished and well developed. He was restless, agitated, confused, disoriented, had a rectal temperature of 102° and complained of vague pains in his leg and buttock muscles. He rubbed his nose and mouth continually and answered questions in an irrelevant, facetious manner. He was ataxic and limped on his left leg. He had a positive Romberg falling backward and to the left. Deep reflexes were diminished in the left arm and leg. The left abdominal reflex was absent. There were no sensory changes.

Laboratory data:—Spinal fluid examination on September 12th and 16th was normal. White blood count on September 12th was 25,000. Differential showed 45% eosinophils. Repeated blood counts showed a rise in the white blood count to 30,000 with 57% eosinophils on September 16th. This gradually fell to 11,000 with 27% eosinophils prior to discharge. Daily urine examinations were negative. The Widal test for typhoid and the test for undulant fever were negative. Four stool examinations for ova and parasites were negative. Stool cultures for typhoid were negative. Blood serology was negative. Blood culture was negative as were x-rays of the skull, chest, and left hip. A skin test for trichinosis was negative on September 12th, but strongly positive on September 19th and again on September 21st. Biopsy of the left gastrocnemius muscle was done on September 22nd and showed a generalized myositis with infiltration of eosinophils. No larvae were found in this section.

Course in Hospital:

He ran a spiking temperature, between 100°-102.8° falling to normal after one week. His face became thinner and lost a diffuse puffiness. His confusion gradually cleared so that after two weeks he was mentally clear, and correctly oriented, but had no memory for his acute illness. At this time he developed pain and swelling of his right face and severe precordial pain which lasted two days. He steadily improved and on discharge, September 28th, his gait and reflexes were normal. He was seen on a follow-up examination on October 16th. He felt better but not well enough to work, complaining of being more tense, nervous and restless than he was before his illness. He complained of some difficulty in judging distances which bothered him in driving and climbing stairs. Neurological examination was negative except for some pain in his lower legs.

In this case, the history of diarrhea, the typhoid-like fever, the vague muscular pains, the high eosinophilia, the skin test initially negative and later becoming strongly positive,[7-10] and a biopsy showing generalized myositis with infiltration of eosinophils lead to a diagnosis of trichinosis. According to Merritt & Rosenbaum[1], Augustine[8] and Spink[9], the above criteria are sufficient to make this diagnosis.

Nineteen cases of psychosis due to trichinosis involving the nervous system have been reported in the American and English literature. An additional case of psychosis associated with trichinosis with recovery is reported.

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Saturday, January 31, 1948

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IT'S YOUR LIBRARY

RECENT VISITORS to the Medical Library have no doubt been impressed by the fresh appearances resulting from improvements made in the building.

The auditorium has lost its previous drab and somewhat dingy aspect. Fresh decorations have livened up the walls. A new lighting system with modernistic features is especially striking. A new wiring arrangement now permits instantaneous shifts of lighting before and after lantern-slide projections or moving pictures. The lack of such an arrangement has been a frequent annoyance to our lecturers. In connection with this change the correction of the wiring system required very extensive ripping of the ceiling, which added to the expense of renovation.

New decorations in the reading room, the Miller room, the coat room, and, lavatory impress the visitor immediately upon entrance.

The entire arrangements of the reading room have been radically changed. The long heavy library table which occupied the center of the room for many years has been removed and shifted to the basement floor. The few small tables previously scattered along the walls are being replaced by larger tables of a size more suitable for real library study. These will have more satisfactory individual lighting for each table. The various book shelves and periodical stands are also to be replaced by more practical fixtures. More comfortable chairs are also being provided.

The reading room will now be used more frequently for small medical meetings, as well as meetings of other communal groups which in the past have used the facilities of the main auditorium.

The stack-rooms of the library are yet to be repainted and will also undergo changes in wiring and lighting, partly for additional safety and partly for increased general efficiency.

In the recent past, extensive repairs have been made to the roof of the building. Renovations have also been made in the sidewalks outside.

All these improvements cost money. A considerable amount has already been spent, and the present program calls for further continued expenses in the near future, within the limitations of our budget. For a number of years very little money has been spent in such upkeep. In consequence, the expenses of putting the building into proper shape have been considerable when concentrated into a relatively brief period.

It must be remembered that the Library Building was not purchased by the Rhode Island Medical Society. It was a gracious and generous gift made to the Society by the medical profession of the State. The acceptance of such a gift entailed the responsibility of suitable upkeep and care. This is a gift which is to be handed down to

future generations of physicians, and necessitates a proper and suitable pride in ownership.

Not many State Medical Societies are blessed with such a beautiful, permanent home combined with a useful, substantial medical library.

The present expenses and the necessary continuing program for future upkeep of the building constitute an appreciable part of the enlarged budget of the Society, reflected in the increase of annual dues.

THE KENNEY CLINIC

The Internes' Alumni Association of the Memorial Hospital, Pawtucket, have revived a delightful and valuable function which they had been forced to discontinue because of the war.

For many years we had looked forward annually to a full day of high grade, well presented clinical material. The staff of the hospital gave the morning program and ably demonstrated the excellent work done there.

After this a bounteous and tasteful lunch was served. We can add with enthusiasm that the kitchen work maintained the high standard of the scientific procedures. This communal eating associated with medical meetings is not to be sneered at, particularly at buffets where one moves about and mingles with friends and acquaintances. Then in the afternoon a group from one of the large Eastern medical centers would put on a program, always well worth attending.

The dens ex machina of these scientific skirmishes was Dr. John F. Kenney, the Chief of the Medical Staff of the hospital. His wide acquaintance and his persuading ways as well as his discrimination resulted in a notable array of brilliant men to instruct us.

Now Dr. Kenney is no longer a staff member but is enjoying an otium cum dignitate. How one who feels his oats as much as John Kenney can lead such an easy life with grace and cheerfulness is beyond our comprehension. Perhaps his medical advisor's choice of a tonic has a bearing on it.

At any rate, the active staff held a meeting on October twenty-nine and again a delightfully varied program pleased us as we always have been pleased in the past. Most felicitously these meetings have been given the name of

The John F. Kenney
Annual Clinic of
The Memorial Hospital

Dr. Kenney was there and evidently enjoying himself hugely. This is a graceful recognition of Dr. Kenney's worth and services and we look forward to many more of these fine affairs with Dr. Kenney enjoying them while his younger associates do the work.

MEETING THE CHALLENGE

The first of January marks the start for the sale of contracts to provide prepaid surgical insurance under the Rhode Island Medical Society's program. With the springing of the barrier we shall not anticipate a wild scramble of insurance agents to claim the potential business. Nor shall we promise great things for our program. We know that it faces a difficult development, but we have the courage of our conviction, and a strong belief in the desire of people in general to protect their own welfare in a free and voluntary manner.

We are in an age of restlessness. There is an undercurrent throughout the world that favors placing many personal rights and privileges under political control to an extent never previously thought possible. All this in spite of the fact that nowhere in the world has political dominance over production and distribution improved the state of the people. America alone has demonstrated that the greatest good can come to a people that is completely free. Yet we here are faced with the same undercurrent that has devastated other countries. We are faced—and particularly those of us concerned with the health of the nation—with direct and indirect charges, with unfounded accusations, and with distorted statistics, all for the purpose of attracting the malcontents and their like to the fountain of political power where the citizen becomes a "subject," and the patient becomes a "case."

In the face of this restless undercurrent we have had the courage to launch a prepaid program the success of which hinges on the initiative and integrity of private enterprise. We see in the insurance industry an agent that has won the trust of the people of this country. We have lowered our indemnities for surgical service to be rendered to persons whose income falls within certain limits. We have assumed the responsibility to see that the insurance contracts meet the requirements of the public, and that their terms are carried out.

We are encouraged by the advance notice from many companies who will operate under our program. These companies rank among the leaders in the insurance field. They have pledged to utilize their resources to promote the principle of budgeting for catastrophic disabilities necessitating surgical procedures for restoration of health. We know the result of their work will not be apparent for a year at least. But we also know that we are building on sound ground—that we are extending medical care in a manner that the public can understand, and in which it has every reason to have complete confidence.

For the individual physician there are tasks, too. He should first become very familiar with the de-

continued on next page

tails of the program in order that he may answer inquiries from patients and friends clearly and intelligently. He should accept every opportunity to encourage the purchase of insurance contracts approved by the Rhode Island Medical Society. He must do all this knowing that the success of the program will not result in any financial reward; rather, it will be the performance of a duty to self, to the community, and to the perpetuation of the American system of personal rights and opportunity.

WE AND DOCTOR GET PAID

Physicians of the state are promising to participate in the proposed voluntary prepaid program of surgical insurance. The plan is similar to the Blue Cross. We pay monthly for service that we may need, and the doctor gets his money quickly and does not wait, or perhaps never gets paid.

The plan is working already in some states. There was a time when the medical fraternity was not sold on the plan. They feared socialization of medicine. That is a plan where a doctor is placed on a salary, and the patient takes the doctor which has been directed to serve this or that community.

But apparently the fear of such a plan has disappeared, as the patient may engage his own physician and the doctor is assured of his pay. So we all ought to be happy.

. . . Editorial, *Westerly Sun,* Tuesday, October 21, 1947

THE PATTERN IS DRAWN

It is with great interest that we in Rhode Island read the announcement in the Connecticut newspapers in mid-November that the Connecticut State Medical Society was to consider at its meeting this month the adoption of a surgical-obstetrical insurance plan similar to that already accepted here.

For years our neighbors have been working on studies of prepaid medical care plans, and with the insurance capitol of the world within their borders they have undoubtedly had opportunity to gain first hand information on the mechanics of a successful prepaid system of budgeting the costs of medical care through insurance.

That Connecticut has deemed it advisable to follow in great measure the program evolved by our Surgical Study Committee is a tribute to the physicians here whose unselfish service for the Society and the public resulted in the outstanding report adopted by the House of Delegates in September.

The pattern is drawn. We may look for its use in other parts of the country in the coming months.

EIGHTH ANNUAL CONGRESS ON INDUSTRIAL HEALTH

The Council on Industrial Health will hold its Eighth Annual Congress on Industrial Health in the Cleveland Auditorium, Cleveland, on January 5 and 6, 1948. These dates immediately precede the Interim Session of the American Medical Association, which will be held in the Auditorium on January 7 and 8. General practitioners supply a large part of the medical services which workers receive through industry, and they are cordially invited to attend these industrial health sessions. The program of the Congress is being constructed with general practitioners in mind and will include discussions of first aid and emergency services in industry, physical examinations, administrative practices, applied physiology, aviation medicine, radiation medicine and practical expositions of occupational disease management, traumatic surgery and rehabilitation. Since full use of medical services in industry depends on support from management and the worker, the essential relationships will be discussed. Industry needs medicine as a practical ally and to promote human relations. The Industrial Health Congresses are intended to further these objectives.

JAMA 135:357 (Oct. 11), 1947

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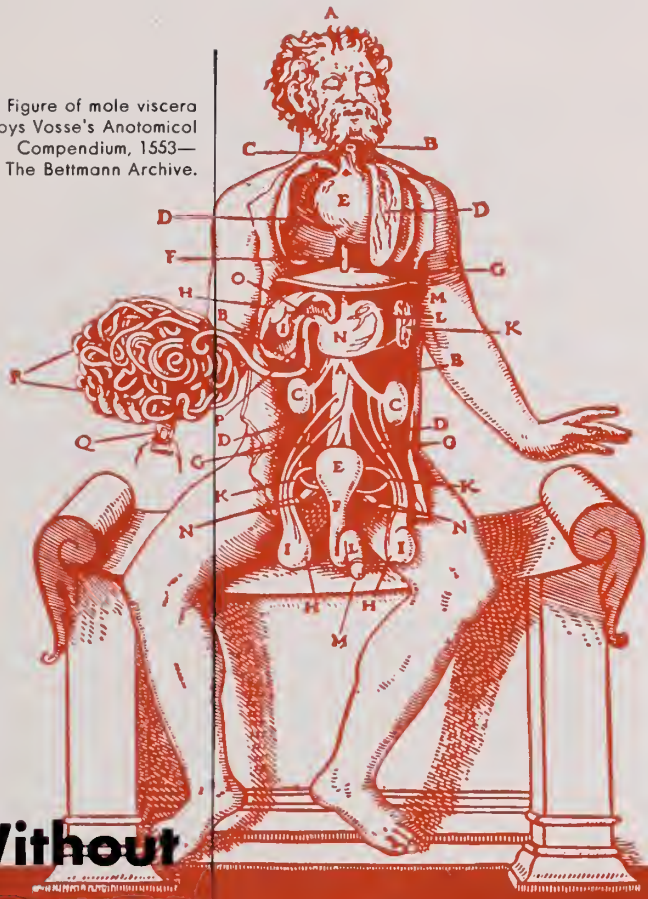
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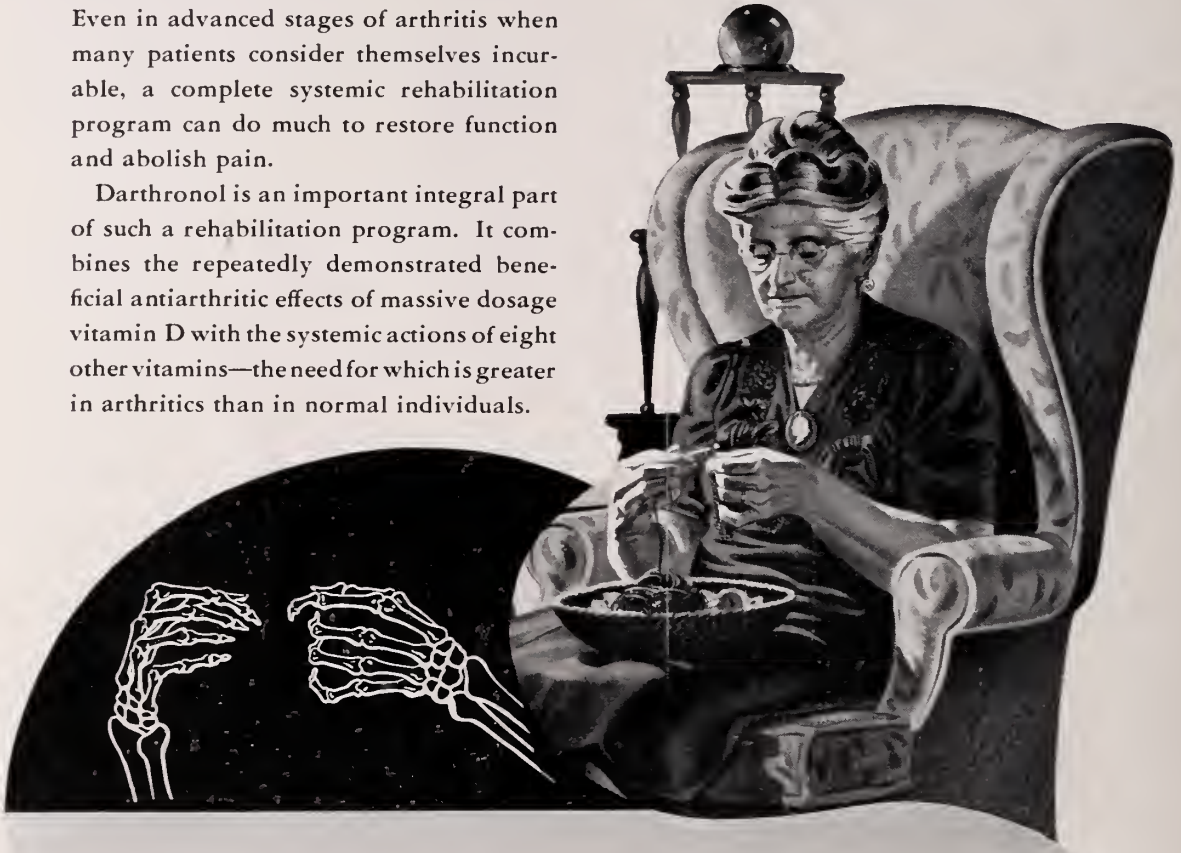
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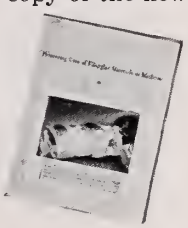


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THE MEDICAL STAFF AND THE HOSPITAL

GEORGE W. WATERMAN, M.D.

The following statement was made by Dr. George W. Waterman at the Annual Meeting of the Corporation of Rhode Island Hospital on November 12, 1947. Although the talk is directed to, and is concerned with the Corporation and Staff of this one hospital, it expresses so well the problems and ideals of all large hospitals that it is reprinted here. *The Editor*

* * * * *

As PRESIDENT of the Staff Association of the Rhode Island Hospital, I am greatly pleased to respond to Mr. Gerry's invitation to address this meeting of the Corporation.

To my knowledge, this is the first time that a representative of the Medical Staff has been asked to take part in this exercise, this Annual Meeting. I believe that this invitation marks a new era in relationship between Corporation, Trustees, Administrative Staff and Medical Staff.

Your Trustees and administrators under the guidance of Mr. Gerry and Mr. Pratt have shown a growing interest and concern over the future of this hospital. They are naturally concerned over the expansion and development of its physical plant and of its essential service departments,—such as nursing, laboratories, etc.,—so necessary in arriving at the prime objective—"Good Patient Care". But beyond this they know and are fully aware of the necessity of providing the best possible medical staff, for without a well trained competent staff, excellent physical plant and services can avail but little in creating what they have in mind, a great medical center to serve the people of Providence and this vicinity.

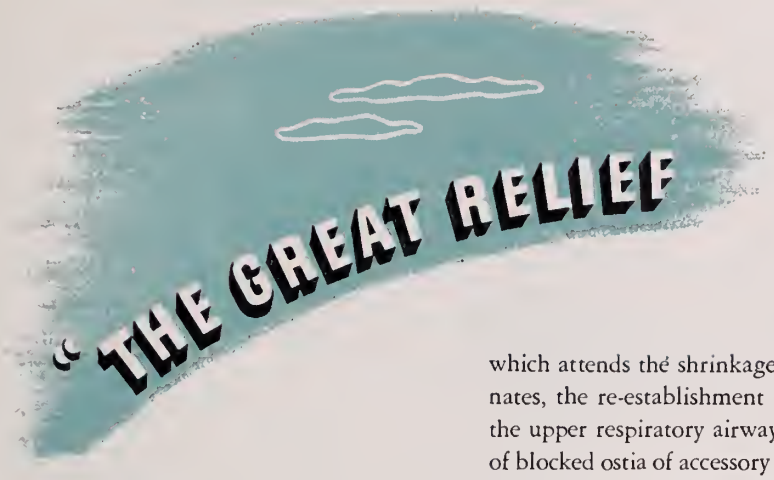
In this day of rapid change and development of medical science, it is axiomatic that such a medical center as is envisioned must be staffed essentially with specialists in the different departments. The chiefs must be specialists, men of initiative and achievement who can carry on and direct research and educational programs and who are thorough masters of the techniques of their specialties. Younger men must be taught first as interns after their medical college requirements are fulfilled, and then as residents where they receive added experience, fitting them for examination by their specialty boards. Finally a place must be found for those best qualified to enter the hospital staff, where they will rise in position according to their merit, to provide continuity of good patient care.

Staff Committees have for several years stressed the need of a program of research and education as a necessity in such a hospital as ours. You may quite naturally wonder why we must take on such a burden. Why can we not leave these functions to the medical schools? The answer is apparent to all good medical men. The spirit of inquiry into the causes and treatment of diseased persons is inherent in the medical mind. With the great amount of clinical material available here for study, the challenge to do something about it is great. To record, to compile statistics, to go on record in writing up case history and reports, to establish new facts, to improve on older established methods and procedures, and thus to contribute something, if only a small something to the sum total of all that is being done today towards the alleviation of human suffering and the prolongation of precious lives,—these are the really worthwhile things to medical men. This spirit of inquiry must be encouraged if we want good medicine.

Why must we have a program of education? Because in teaching others the principles and practice of medicine we educate ourselves. We need the contact of young developing minds. To answer the searching questions these young men ask disciplines our thinking, makes us want to be more sure of our grounds and careful in our judgments. The teaching instinct must be strong in us and we must have opportunity to use it if we would be good doctors.

Why must we have good staff organizations and staff relations? Because in such a highly specialized institution as yours is, there must be the closest integregation between departments. We must know and respect each other as men who have a common cause, the best care for the sick person. We must consult when occasion arises, e.g., where complications arise during an illness, surgical, medical, etc., we must have the best opinion on the complication from the proper specialist with his special knowledge of such conditions. The internist may call on the special services of the biochemist or pathologist for blood studies and other laboratory procedures which aid in the diagnosis and treatment, on the X-Ray department or other service departments. In the medical center the patient has the best opin-

continued on page 880



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MEDICAL STAFF AND THE HOSPITAL

concluded from page 878

ion at a moment's notice from any department deemed essential to his care. The best Patient Care is no longer and cannot be a one man affair. It has become the responsibility of the whole closely integregated organization.

The programs of research, education, and good staff organization in a hospital of 500 beds are recognized as "musts" by the A.M.A. and the American College of Surgeons. In fact recognization of this hospital for the training of interns and residents is dependent on the established evidence of their presence.

We have recognitions for the training of interns. We have recognition of residencies in surgery, medicine, orthopedics and fractures, anesthesiology, cardiology, pediatrics, pathology, roentgenology and are in process of recognition in gynecology. We have already come a long way.

The medical staff at the Rhode Island Hospital has for many years rendered invaluable and excellent service in this community. Many brilliant and able men have played a part in its development. Its internship has been highly valued and has been the training ground for many men who have gone out and made a sure name for themselves, both nationally and locally. But we men of today cannot rest on past laurels. We have a big job ahead.

To say that everything is "just great" would be smug and unworthy of us, unworthy of any staff. We have a sound core. We are carefully studying weaknesses, learning to recognize them, and will correct them as the solutions become clear. Our aim is high. With all that we have at hand, all that we hope to get in better facilities with the opening of the new hospital, with the sympathetic understanding and help of our president, corporation and trustees and of our administrative staff, we shall create a medical staff worthy of the great medical center to which we all look forward, to which our citizens can look with pride and to which they can turn with sure confidence in their hour of need.

Miss Agnes V. Davis, R.N.

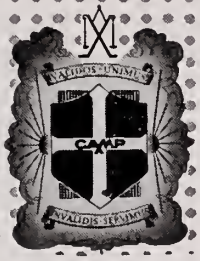
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THE EDUCATION OF THE NURSE

In the July issue of the RHODE ISLAND MEDICAL JOURNAL (Vol. XXX, No. 7) a discussion of the education of the nurse, offering some interesting observations on the nurse problem of today, was submitted by a member of the Rhode Island Medical Society who has a wide background in medical and nursing problems as they have existed in this State for many years. The Editors of the JOURNAL considered the communication a presentation worthy of general reading, and therefore published it with the name of the author withheld. In publishing the discussion neither the R. I. MEDICAL JOURNAL, nor the Society, endorsed the opinions of the writer of the communication. Therefore, the Editors willing devote space here for a reply from the Rhode Island State Committee on Nursing Education.

November 7, 1947

Editor
RHODE ISLAND MEDICAL JOURNAL
Rhode Island Medical Library
Francis Street
Providence, R. I.

Dear Doctor:

Enclosed is a copy of a reply to the article which appeared in the July issue of the RHODE ISLAND MEDICAL JOURNAL.

The State Committee on Nursing Education would very much appreciate your giving this reply consideration in as early an issue of the MEDICAL JOURNAL as possible.

Thank you for your consideration.

Very truly yours,
CECILIA E. WALSH, R.N., *Secretary,*
Nursing Education Committee

* * *

NURSING has news value at this time because of the ever increasing demand for nursing service. Because of this need many groups are beginning to share with the profession the great responsibilities involved in preparing young women for the care of the sick.

The Rhode Island State Committee on Nursing Education is vested by statute with the responsibility of "setting forth and maintaining standards for schools of nursing, placing schools on the accredited list upon application and proof of qualifications and making such rules and regulations for the administration of the Chapter as will improve nursing education in the state". This group, therefore, was pleased to see an article appearing in the July issue of the RHODE ISLAND MEDICAL JOURNAL *entitled* "The Education of the Nurse" since it is logical that the medical profession should be interested in this phase of education.

It was a disappointment, however, upon reading the article to realize that it was written anonymously and that it contained assumptions which required clarification. The first of these assumptions is that professional nursing is opposed to the establishment of courses for the preparation of practical nurses. The profession has taken the initiative both nationally and locally in paving the way for the initiation of vocational training for women who will share in providing adequate care of the sick.

The Committee on Nursing Education in conjunction with nurses in the state have approached and encouraged the Rhode Island Director of Education to establish the vocational course for practical nurses which is being sponsored by the U. S. Office of Education. These plans are under advisement by the Director at the present time and we hope will shortly materialize. Even before this National program was available a local hospital requested permission to set up such a course under its auspices. The Committee on Nursing Education gave much help and professional advice to this hospital which conscientiously sought to meet its need for nursing service in this way. In spite of great plans and expenditure of funds there were no applicants for the course. It was obvious that part of the lack of applicants was due to the fact that Rhode Island has no statutory provision for the licensure of practical nurses. This provision was then incorporated as part of the Health Bill which for two successive legislative sessions has failed of passage. It appears that such legislation is a definite prerequisite for the establishment of any course for practical nurses and it is sincerely hoped that this Bill will receive favorable consideration by the next session.

Young women graduating from high schools to-

continued on page 884

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EDUCATION OF THE NURSE

concluded from page 882

day are rightfully searching for the professions which will provide the satisfaction and remuneration for which their qualifications entitle them. It is the school demanding the highest qualifications, not the least, to which these women are attracted. This is not only true in Rhode Island but all over the world.

Another assumption contained in the article referred to is that nurses are responsible for the fact that patients admitted to hospitals do not have sufficient people to care for them. The facts as stated by the Hospital Association are that hospital admissions have increased 100% within the past ten years. The number of graduate professional nurses has also increased but only by 13% which is a large increase when one considers the many opportunities open to young women these days, but is not sufficient to meet the service needs of hospitals.

The Committee on Nursing Education has based its criteria for evaluating the curriculum of schools of nursing in the state on the activities which nurses are required to perform. A recent spot check was made of the activities carried on by student and graduate nurses at the University of Rochester School of Nursing during a twenty-four hour period. These activities were performed on a general ward exclusive of the emergency wards, operating rooms and outpatient departments. The director of the nursing service reporting states that the checking was not intended to be exhaustive but to give some idea of what is expected of the nurse. The following are some of the items listed: Constant attendance upon patients in respirators; the giving of gavages; the placing of fifth leads for electrocardiograms, application of suction to surgical wounds, tracheotomies; chest cavities, and throats; the managing of apparatus for Wangensteen suction, tidal irrigation and bladder decompression; irrigating eyes, cecostomies, colostomies; the giving of artificial respiration until respirator arrived and then starting the apparatus; using Danzer apparatus; the giving of insulin and teaching of patient to give the treatment; specialling patients after craniotomies, tracheotomies, and other surgery.

The director went on to say that all of these procedures were administered with no more direction by the doctor than the writing of the order. It is natural that he should expect that the nurses would be skilled and intelligent enough to carry out his orders and that when he returned he would find everything completed to his satisfaction.

The fact that the nurse on the ward does know these things is taken for granted now; but what would happen if all nursing of the sick were entrusted to women who only had as much preparation as that being advocated by the writer in his article?

Persons responsible for the education of nurses could take the easiest course at this time and succumb to the pressures which are advocating the turning over of nursing of the sick to a less well prepared group of women than exist today. In doing so, however, it recognizes that it would only be a short time before the resultant chaos would bring censure from the same group which now thinks that shortened courses are the only answer.

The Committee on Nursing Education, therefore, would welcome the opportunity of planning cooperatively with the Rhode Island Medical Society in meeting the nursing needs of the community of which we are all so keenly aware.

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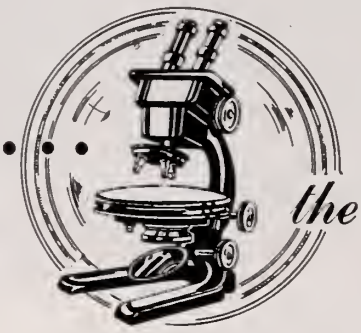
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THROUGH . . .  *the Microscope*

Special Services The question of just where hospital services end and medical services begin has been a topic that many a physician has debated, especially since the Blue Cross hospitalization programs expanded through our communities. The Massachusetts Medical Society decided to do something about defining the terms. A committee headed by Dr. McKittrick of Boston, and comprising two members each from the Blue Shield, the Blue Cross, and the Massachusetts Hospital Association, the state Medical Society, and the specialties of radiology, pathology, and anesthesiology tackled the problem.

The committee came up with the definition of non-medical services as including administration, nursing, social service, record room and library, pharmacy, dietary service, housekeeping and laundry, maintenance of buildings, etc., provision of technical and non-technical personnel and their supervision, reports without interpretation from the clinical laboratories, and "such other services as may be necessary for the operation of a hospital.

The medical services were defined as "those services other than administrative rendered by a registered physician directly or indirectly to or in behalf of an individual patient for the obtaining and interpretation of data, including consultation and advice for the diagnosis, treatment and prevention of disease."

We note with interest that the committee also expressed the belief that (1) medical costs of hospital care should be separate from non-medical costs, (2) bills for all medical services should be rendered in the name of the physician performing the services, (3) that each part of the hospital be self-supporting in so far as possible, and (4) that fees for medical services collected by the hospital should be established by joint action of a representative committee of the staff and governing body of the hospital.

Toward Better Health The Research Council for Economic Security has recently released its latest publication giving a survey of existing facilities and their potential development. The material is excellently presented. Notable observations include: (1) In answer to the question as to where existing plans for health protection fall short, attention is directed to the fact that it is not necessary, nor is it possible nor desirable that everyone in the United States should be reached by the same kinds of health program; (2) The means by which various programs can be expanded will not be the same, i.e. for some it is matter of money, others, education of the public, and for still others development of personnel; (3) health conditions vary from one location to another; (4) growth of any part of a health program is of most benefit when it is a balanced growth—going forward on all fronts at about the same rate; (5) The American people want better health, but nevertheless they are a practical people, interested in practical results, not dreams or theories.

One point seldom ever brought forward in health discussions was advanced by Dr. E. E. Vincent Askey, president-elect of the California Medical Association, who told the Conference on the Cooperation of the Physician in the School Health and Physical Education Program last October that "the public should be educated to expect some amount of illness as a normal outlook rather than to expect that good health is normal and that illness is something unusual." He added, too, that "children should be taught that sickness, accidents and disability are not an abnormal expectancy in life."

Mercy Cars The Worcester MEDICAL NEWS recently published an open letter to Governor Robert F. Bradford, and to Mayor Charles F. Jeff Sullivan, as well as the Mayors of all the cities in Massachusetts, calling to their attention the hazards on crowded highways caused by ambulances rushing in record breaking speed to hospitals. Citing the fact that the city of Providence limits the speed of ambulances and fire apparatus to 25 miles per hour, the NEWS

continued on page 888

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THROUGH THE MICROSCOPE

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seconded the editorial statement in the *New England Journal of Medicine* that "racing over congested highways may shorten the length of time in getting to the hospital, but it is only occasionally that the minutes gained are of any benefit to the patient and may be truly harmful to one seriously injured." There is little doubt that more lives have been endangered, as the NEWS points out, by swiftly moving ambulances than have been saved by the hurried arrival at the hospital. But in our opinion the speed limit should not hold only in the congested areas, but throughout the state ambulances should respect the maximum travel speeds for all traffic. The siren and flashing light of an ambulance guarantees it a right of way that is willingly given, in our observation, by all motorists. The tragic death of the Woonsocket family group recently focuses attention on the need for consideration of this situation in Rhode Island.

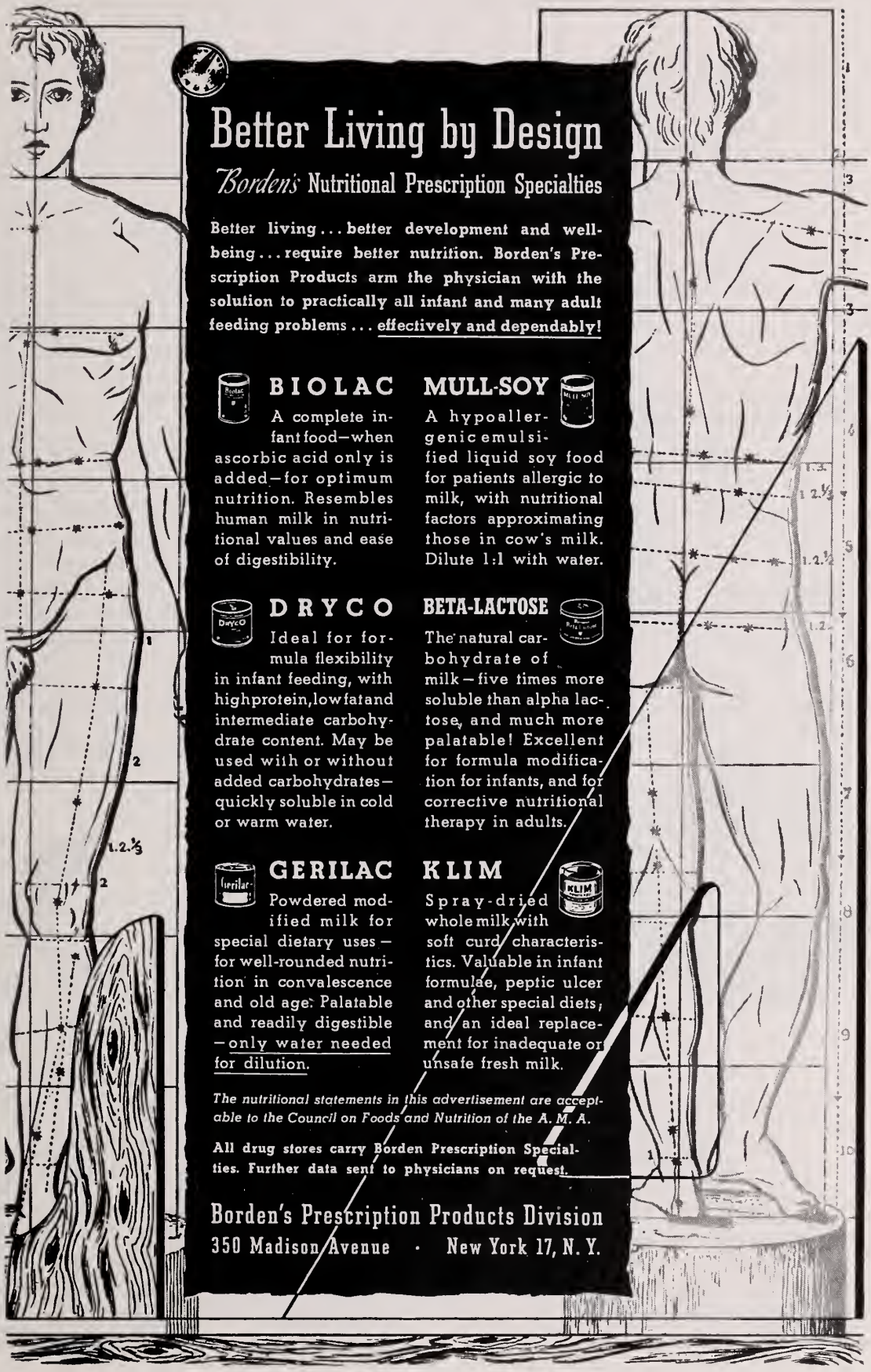
County Society Meetings

Why don't more physicians attend monthly meetings of their county medical society? That question has undoubtedly puzzled many a county society president, and his program committee. The Philadelphia County Medical Society decided to take the question to its membership. A postcard questionnaire sought the information of each member (1) whether he attended meetings or not, and (2) what suggestions he could offer to improve programs and attendance. Replies from 500 members came back. Main reason for not attending: evening office hours make it difficult or impossible to get to early evening sessions. Other reasons advanced for absences: too busy; age; physical disabilities; distance, too many conflicting meetings; only interested in specialty meetings. Constructive suggestions included: more short, simple discussions of latest practical methods of diagnosis and treatment to keep general practitioner up-to-date; less information on etiology and pathology or rare and obscure diseases; more time and opportunity for discussion from the floor; more discussion of medical economics and public health problems.

When Your Hair Has Turned to Silver

The energetic Doctor Theodore G. Klumpp, newly-appointed head of the new Winthrop-Stearns pharmaceutical combine, had some worthwhile comments on the archaic system in this country of "pensioning off faithful retainers" solely on the basis of calendar age when he addressed the New Haven (Conn.) Medical Society at its annual meeting late in October. Warning of a severe economic dislocation

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THROUGH THE MICROSCOPE

concluded from page 888

ahead if we persist in dumping workers in the "old age boneyard" when they reach a fixed age, Doctor Klumpp cited statistics of age groups to prove that by 1980 there would be potential labor surplus of 30 million workers if the elderly were scrapped summarily. Predicting a thirty-hour week in industry in a generation, he offered the following recommendations for adoption by federal, state, city governments and heads of industry: (1) abandon compulsory retirement on calendar age basis since physiological age is not the same as chronological age; (2) plan for retirement on a selective basis of fitness to do a given job; (3) base compulsory retirement on the recommendation of a retirement board composed of medical and psychiatric members as well as administrative officials; (4) offer opportunities for down grading in position and salary to the aging worker; (5) encourage industry, governmental and private institutions to make a greater effort to employ partially disabled persons; (6) change institutions for aged and disabled from asylums to modern institutions where every convenience and scientific development would be available for physical, mental and spiritual comfort.

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VA HOME TOWN MEDICAL CARE PROGRAM

A summary of the highlights of the Conference on the Veterans Administration Home Town Medical Care Program sponsored by the Council on Medical Service of the American Medical Association, at Chicago, November 6, 1947.

THE MORNING SESSION of the Conference was devoted to presentations of the experiences of state medical associations with the V A program. Reports were made by Dr. Ralph H. Creighton for the North Central States; Mr. John Castellucci, director of the veterans care program administered in Michigan through Michigan Medical Service; Mr. Oliver Ebel, for the Kansas Medical Society; Dr. A. E. Larsen, medical director, California Physicians' service; and Mr. W. H. Tibbals of Utah, for the Rocky Mountain region.

Of the programs discussed that of Kansas was of particular interest to the Rhode Island delegation in view of the fact that it is a plan under the medical society supervision, and not under a medical care plan administration.

In Kansas the county medical societies grade the specialists in their district. Veterans filing pension claims are handled by the regional VA at its facility when possible, and otherwise are sent to physicians on the approved list according to the speciality, and on a rotating basis to provide equal distribution of the work among the doctors.

Under the program the VA notifies the veteran claimant to report for a physical examination. The executive office of the state medical society also receives a copy of the order. The completed examination report in turn goes to the medical examiner-coordinator at Topeka who checks on the report before it goes to the rating board. The State Society's cooperating committee meets weekly to check forms not properly made out. Forms in the latter category are returned to the physician for correction, and then come back to the medical co-ordinator, and thence to the rating board. The Committee averages a weekly check of 90 forms, and of this number about 15, on an average, are returned for correction.

When the Kansas plan was initiated the executive secretary of the state society and the medical co-ordinator of the VA visited each county society to inform the members fully regarding the plan. As a result the experience in the past year has been most favorable.

* * *

Severe criticism of the Home Town Care program as operating in the Rocky Mountain area was submitted by Mr. W. H. Tibbals, executive officer of the Utah Medical Society. He read a letter from the presidents of the medical societies in the Rocky Mountain area sent to the administrator of the Veterans Administration protesting the setting of a maximum fee schedule in Washington, D. C., for the entire country.

Second major criticism of the Rocky Mountain group was that physicians in the rural areas state that if the VA continues to expand its program whereby it handles patients through its own staff in its own facilities, then physicians and small hospitals in rural areas will suffer a severe economic loss by reason of the assigning of patients to the VA clinics. The abuse of the VA medical privileges whereby veterans are given care for non-service connected disabilities was also cited.

* * *

Dr. Bauckus, speaking from the floor, reported that in New York state the co-ordinator system was being used with the medical co-ordinator in the employ of the medical service corporation of New York which works closely with the VA in handling the veterans medical problems. He noted that in the past six months there has been a restricting of free choice, giving as examples that surgery is free choice only in an emergency, and that after January 1 there will be no allowance for neuro-phychiatry by private physicians in New York city.

DOCTOR HAWLEY COMMENTS ON PROGRAM

DOCTOR PAUL R. HAWLEY, chief medical officer of the Veterans Administration addressed the Conference in the afternoon session, highlighting the position of the VA in its relations with the medical profession, and the various medical societies, in the handling of the medical care of the veterans.

As the program interests the general practitioner, he stated, two views have been widely expressed, (1), that the private practitioner should

have no part in the program, leaving it entirely to the VA staff, and (2) that the VA should get out of the field and leave the medical care to the private physician.

Answering these two criticism Doctor Hawley pointed out that it would be impossible to build a VA staff big enough to handle the patient load, and therefore proposal 1, as above, must be opposed. As for the second critcism, he claimed that it would be impracticable, if not impossible, to leave the outpatient medical care of the veteran to the private physician. His reasons were several. They included: (1) Some kind of administration is necessary, and with the expenditure of government money there must be authorization by a responsible agency; (2) to administer the medical program a sizable medical staff is an absolute necessity, for the experience of the past two years has indicated that it is almost impossible to get 100% reporting on pension claims from private physicians; (3) adjudication of claims is by lay boards who require interpretations of the medical findings regarding various disabilities, hence it is necessary that the VA maintain a medical service trained in handling claims for pensions.

In answer to the criticism from various parts of the country that the private practitioner was not seeing the veteran because the VA was establishing outpatient clinics (similar to the setup in Rhode Island at the old Hope high school), Doctor Hawley stated that the VA is forced by law to maintain these clinics, and must keep the personnel attached to them busy. However, he claimed that the VA has no intention of expanding the outpatient facilities of its own. He reported that in 1941 there were 51 regional office outpatient clinics for four million veterans, and in 1947 there were 70 regional office clinics for eighteen million veterans; hence the expansion has not been proportional to the possible patient claim load. However, he did state that the VA now has 1,300 full time physicians on duty in outpatient clinics.

As evidence that the private practitioner would continue to be the key person in the medical care of the veteran, Dr. Hawley related that by next June 30 it is anticipated that 858,000 examinations will be done by private physicians, and by June, 1949, the annual total will be close to one and a half million.

In reply to the charges from the Rocky Mountain region (see above) that the VA was trying to adopt a national fee schedule, Dr. Hawley stated that no such purpose was intended. He did admit that a letter sent out from national headquarters was badly worded, and it gave a false idea of the reason for the schedule drafted at the Washington office. Turning on his critics he expressed the personal opinion that he was not certain that it was any great crime if the VA announced fees provided it is clearly understood that the physician can accept the fee or not, or can accept the patient or not. The VA schedule, he stated, resulted from a study made by a group representing all the specialties, and it provided a fair average for charges to be used as a guide only and subject to local community conditions.

Among questions directed at the VA medical director in the open forum after his presentation was what the VA is doing to cut down the use of the medical care program by veterans with non-service connected disabilities. The answer was that when there is a vacant bed the VA will admit a patient with a non-service connected disability, by reason of Congressional action directing such procedure. In the fiscal year ending in June some 23 million dollars was spent for care on non-service connected cases, and the figure is expected to be close to 40 dollars for the fiscal year ending next June. Meanwhile, 60% of the hospital service is reported to be for care of non-service connected cases.

Hospital staffing will continue as already planned, with the local profession furnishing part-time service as staff members and as consultants. Selections for appointments will be on the basis of qualifications set up by Dean's committees where medical schools exist, and otherwise, as in the case of Rhode Island, by the state medical society.

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DISTRICT SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, November 3, 1947. The meeting was called to order by the president, Dr. Guy W. Wells at 8:35 p.m.

The minutes of the previous meeting were read by the secretary and were accepted without any corrections.

Dr. Philip Batchelder, chairman of the Centennial Celebration Committee, reported briefly on the progress towards the plans for the 100-year observance of the Providence Medical Association. He stated that the observance would be centered in the last week in January of 1948 and would be climaxed with a dinner for the members and their guests at the Biltmore Hotel on Saturday, January 31, 1948.

Dr. Wells stated that at the previous meeting of the Association the surgical insurance plan of the state Medical Society had been unanimously endorsed. He stated also that each of the district medical societies in the state had taken the same action. However, he noted that many Providence physicians have not as yet signed the physicians participating agreement and he urged them to do so.

Dr. Wells reported that he had named a Committee consisting of Dr. Herbert Partridge and Dr. Pearl Williams to prepare the Association's tribute to the late Dr. Jay Perkins.

Dr. B. Earl Clarke, member of the Cancer Committee of the state Medical Society, spoke briefly relative to the benefit football game, the proceeds from which to be turned over to the Rhode Island chapter of the Cancer Society to further its work. He stated that tickets would be available for purchase from him immediately after the meeting of the Association.

Dr. Wells introduced for the first speaker of the evening Dr. William P. Buffum, Chief, Pediatric Service, Rhode Island Hospital, who spoke on "THE CHARACTERISTICS OF ASTHMA IN INFANCY". Dr. Buffum stated that asthma occurring before the age of two is not uncommon. In 32 per cent of 265 cases, the asthma began before the age of two. These cases are more severe than those beginning after two. Twice as many boys as girls have asthma.

He then showed case records of babies with asthma, their skin reactions and treatment results. Striking improvements in these cases were obtained by avoidance, desensitization, and penicillin.

Children usually show reaction to many things. The main point Dr. Buffum made was that if the children are treated for the major two to three things they are sensitive to, they are made comfortably better, although they still have some asthma, showing they are sensitive in some degree to many other things.

The discussant of the paper was Dr. Stanley Freedman, Associate Physician, Rhode Island Hospital.

The "PATHOLOGY OF ALLERGIC REACTION TO SULFONAMIDES IN A CHILD" was presented by Drs. Melbourne Brunett, Resident in Pathology, Rhode Island Hospital, and Robert J. Williams, Associate Pathologist, Rhode Island Hospital.

Dr. Burnett stated that as a rule tissue reactions are not specific, in most cases, reactions are generalized in all organs of the body. The sulfonamids, however, give specific reactions.

He presented a case of a child that had intravenous sulfadiazine and died 60 hours later.

Autopsy revealed areas of necrosis and parenchymal hemorrhages. Myocardial infarction, acute splenitis myositis, generalized lymphadenitis nephritis and nephrosis were found.

These pathological changes have only recently been recognized.

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DOCTOR CHASE HONORED

At the conclusion of the annual conference of medical society secretaries and state medical journal editors held at the American Medical Association headquarters last month Dr. Peter Pineo Chase, editor-in-chief of the RHODE ISLAND MEDICAL JOURNAL was one of five named to plan the program for the 1948 conference.

Named to serve with Dr. Chase were Dr. Dwight L. Wilbur of California, Dr. Philip E. Blackerby of Kentucky, Dr. Earl Whedon of Wyoming, and Mr. Charles H. Crownhart of Wisconsin.

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1. Lennox, W. G. (1947), Tridione in the Treatment of Epilepsy, J. Amer. Med. Assn., 134:138, May 10. 2. DeJong, R. N. (1946), Further Observations on the Use of Tridione in the Control of Psychomotor Attacks, Am. J. Psychiat., 103:162, Sept.

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DISTRICT SOCIETY MEETINGS

concluded from page 894

Dr. Williams in the discussion did not believe the pathology in this case was similar to endarteritis nodosa.

The meeting was adjourned at 10:20 p.m.

Attendance 92

Collation was served

Respectfully submitted,

DANIEL V. TROPPOLI, M.D.
Secretary

BRISTOL COUNTY

A meeting of the Bristol County Medical Association was held Tuesday, October 21, 1947. The meeting was called to order at 9:15 p.m. at the Warren District Nursing Association with Dr. Marcius Merchant presiding. Those present included Doctors Bruno, Bray, Creamer, Drew, Dunbar, Forget, Giura, Holdsworth, Lewis, Merchant, Millard, Petrucci and Clark.

Minutes of the last meeting were read and approved.

The application of Dr. Charles W. Dunbar of 10 Appian Way, West Barrington, for membership in the Bristol County Medical Association was received, and Dr. Dunbar was unanimously elected to membership.

It was agreed that various individuals were to be responsible to make arrangements for meetings for the rest of the year.

Associate members would be assessed dues of $5.00 per annum, with the exception of Dr. Bernardo who was elected to honorary membership of the Society without dues. It was agreed that dues for regular members would be $12.00 per annum.

Dr. Francesco Ronchese, of Providence, introduced by Dr. Merchant, gave an instructive talk, illustrated with lantern slides, on common dermatological conditions.

The rest of the evening was devoted to a discussion, led by Dr. Giura, of the Rhode Island Medical Society Surgical Plan. After the discussion the Association voted to go on record endorsing as a group the report of the surgical insurance plan committee of the Rhode Island Medical Society, and further voted to so inform the Rhode Island Medical Society.

Respectfully submitted,

SAMUEL D. CLARK, M.D.
Secretary

KENT COUNTY

The October meeting of the Kent County Medical Society was held Tuesday, the fourteenth at 9 p.m. in Dr. Peter Erinakes' office. Fifteen members were present.

Beginning the evening, a film, "Continuous Spinal Analgesia in Caesarian Section", was shown by representatives of Abbott Laboratories.

Later, a discussion of the Surgical Plan sponsored by the Rhode Island Medical Society was presented by Dr. Rocco Abbate, chairman of the committee which developed this idea. All physicians present certified their willingness to participate in the plan as offered.

Dr. Robert Whitmarsh, chief surgeon at Roger Williams General Hospital, was guest speaker. Diagnosis and treatment of Gall Bladder disease were thoroughly outlined and the proper places of Medical and Surgical Management in this malady were elaborated.

This meeting was adjourned at 11 p.m.

Respectfully submitted,

FRANCIS D. LAMB, M.D.
Secretary

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Society was held October 23, 1947, in the Nurses' Auditorium of the Memorial Hospital. The meeting was called to order by the President, Dr. Earl Mara, at 9:00 p.m.

The Prepaid Surgical Plan was discussed in detail by Dr. Mara who suggested that all physicians give their approbation regardless of whether or not they were doing surgery.

The speaker of the evening was Dr. Robert L. Williams, Associate Pathologist of the Rhode Island Institute of Pathology who discussed "Clinical Application of Bone Marrow Biopsies." Dr. Williams illustrated his remarks with a fine series of micro-slides.

The meeting adjourned at 10:30 p.m.

Nineteen members attended.

Respectfully submitted

KIERAN W. HENNESSEY, M.D.
Secretary

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WOMAN'S AUXILIARY

THE FALL MEETING of the Woman's Auxiliary to the Rhode Island Medical Society was held on October 27, 1947, at the Rhode Island Medical Library.

The meeting was called to order at 10:30 a. m. by the President, Mrs. Herbert E. Harris.

The Secretary's report was read and approved.

The Treasurer reported a balance on hand of $281.60.

Mrs. Bertram H. Buxton, Chairman of the Organization Committee, reported that her Committee had met. They recommended that membership cards be printed.

Mrs. Earl Mara, also on that Committee, inquired as to the possibility of having a membership list published in the RHODE ISLAND MEDICAL JOURNAL so that the various district chairmen would know who the paid members were in their district.

Reports from the Convention at Atlantic City in June were read by the Delegates, Mrs. Charles H. Ashworth and Mrs. Charles L. Farrell.

The President also read her report.

Mrs. Frederick H. Stevens of Bristol inquired as to the possibility of having Auxiliary meetings at night in conjunction with the Rhode Island Medical Society meetings. The President referred the matter to the Board of Directors for a decision.

Mrs. Stevens also asked for volunteers for the Children's Heart Clinic.

It was moved by Mrs. Bertram H. Buxton that greetings be sent to Mrs. Guy W. Wells, our Vice President, who is ill. Mrs. Frank Hanley seconded that motion. The motion was carried.

A motion to adjourn was made by Mrs. Paul C. Cook and seconded by Mrs. Joseph C. Johnston and was adopted.

The meeting adjourned at 11:15 a. m.

Following a business meeting a very interesting historical motion picture was shown by Chief Rosa of the United States Navy. This was in conjunction with Navy Day observance. The picture was entitled, "The Black Cat" and showed some of the activities of our fighting planes during the war.

The afternoon session was called to order at 2:00 p.m. by the President who then introduced Dr. Arthur H. Ruggles, President of the Rhode Island Medical Society.

Dr. Ruggles greeted us on behalf of the Medical Society. He then introduced the speaker of the afternoon, Clair E. Turner Dr.P.H., former professor of Public Health at M.I.T., and now assistant to the President of the National Foundation for Infantile Paralysis.

The subject of Dr. Turner's address was, "Need for a State-Wide Health Education Program".

In his opening remarks, Dr. Turner paid tribute to Dr. Charles V. Chapin and expressed commendation of his achievements. He also spoke of the progress being made in education in Rhode Island.

Dr. Turner quoted from his recently published book, "Health Education and School Health" and drew comparisons between these subjects. He discussed four phases of Health Education:

1st: Direct health-hygiene instruction of children.

2nd: Industrial health—a planned day physically and mentally.

3rd: Healthy and properly trained teachers with sound relationship.

4th: Sound relationship between school health and community health.

Dr. Turner hopes that some day the common cold will be treated as a communicable disease. He also stressed the need for alert salaried men for constant supervision of restaurants.

The Woman's Auxiliary was gratified by the large attendance of Public Health nurses.

The meeting adjourned at 3:15 p. m.

Respectfully submitted
MRS. CHARLES L. FARRELL
Secretary

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RHODE ISLAND REGIONAL COMMITTEE ON FRACTURES OF AMERICAN COLLEGE OF SURGEONS

The annual executive meeting of the Rhode Island Regional Committee on Fractures of the American College of Surgeons was held at the Rhode Island Medical Library on November 5, 1947. Dr. Henry McCusker was re-elected chairman, and Dr. Robert T. Henry was re-elected secretary-treasurer.

The chairman spoke briefly about the clinical meeting of the New England Committee to be held in Boston on November 14, and then elaborated on the requirements of the state regional groups. The work of the various Rhode Island Regional sub-committees was then reviewed and satisfactory progress was noted. Dr. McCusker brought up for discussion the problem of rehabilitation of fracture patients in Rhode Island. He explained the growing interest in rehabilitation work which had proved so efficacious in the American Army hospitals. It was generally agreed that the present treatment of fractures was fairly acceptable and standardized but that late after-care in serious injuries was a pressing and important problem. After discussion of the problem by various members of the committee it was decided that a sub-committee should be formed to explore the need for a reconditioning center in this state.

The chairman appointed to this committee on Rehabilitation: Arthur E. Martin, M. D., Chairman; Herbert E. Harris, M.D.; Walter J. Molony, M. D.

The following sub-committees were also appointed to serve during the next year: Membership, Robert T. Henry, M. D., William A. Horan, M. D., Henry McCusker, M. D.; Clinical Meetings, Louis A. Sage, M. D., James C. Callahan, M. D., Walter J. Molony, M. D., Armand A. Bertini, M. D., James R. McKendry, M. D.; Hospital Care and Equipment, John Paul Jones, M. D., Augustine W. Eddy, M. D., S. G. Lenzner, M. D., S. S. Farago, M. D.; Relations with Other Organizations, Peter Pineo Chase, M. D., Kenneth G. Burton, M. D., Arthur E. Martin, M. D., William A. Stoops, M. D.

HENRY MCCUSKER, M.D.
Chairman

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AS IT LOOKS FROM NEW ENGLAND*

Wisconsin is but one of many state, area, or specialty medical societies. Its perspective is that of a midwestern state. But its problems, at least in part, are also problems elsewhere. These pages are provided periodically for the reactions of medical leadership in other parts of the country.



J. E. FARRELL

John E. Farrell, awarded an honorary Doctor of Science degree in June by Providence College as an outstanding executive officer and health educator, has been the executive secretary of the Providence Medical Association since 1938 and of the Rhode Island Medical Society since 1943. A fellow of the American Public Health Association, in 1945 he was instrumental in forming the Council of the New England State Medical Societies, of which he serves as executive secretary-treasurer.

Consider Wisconsin with more than five million additional residents, and then divided geographically into six separate states, each independent in thinking, planning, and government. Then you have in brief some idea of the size, population, and administration of the New England states as compared to Wisconsin.

New England is a distinct region, steeped in historic traditions and provincial in many of its attitudes. Yet it represents within its confines a kaleidoscopic view of all America. With five of its states having access to ocean waters, with three states marked by mountain peaks and large lakes, and with two states 60 per cent rural and the other four better than 60 per cent urban, New England permits a wide range of productive activities. Thus, for example, Rhode Island has the largest per capita industrial output of the nation; Vermont one of the highest ratios of dairy cows per capita.

Regional Consciousness Developed

With the many problems distinct to other sections of the country, industrial and agricultural, arising with the northeastern states, it is not surprising that the area has developed a regional consciousness that has resulted in a better understanding of issues common to all. And this same theory of regional thinking and planning has now been extended to questions of medicine and health by the state medical societies.

In the summer of 1945 the Council of the New England State Medical Societies was organized at a meeting held in Providence, Rhode Island. Delegates from the six state medical societies in the region were in accord with the general principles which call for a

> "closer cooperation between the state medical societies in New England in the development and the maintenance of the highest standards in the conduct and the administration of medical care, in the development of plans relative to the better organization of medicine, and in the furtherance of plans to improve the health of all the people in the New England States."

Proceedings of the Council

The council has sought to deal only with those major issues in which all the societies are concerned, recognizing that each society has its own peculiar problems that cannot be solved by any general provision. As a deliberative group the council seeks to educate the leaders of the various state medical societies, representing a medical population of approximately 14,000, on matters common to all, thereby bringing about a stronger unit in planning for organized medicine.

Thus, for example, the vexing question of medical licensure by endorsement was finally worked out through the cooperative effort of the council and the officers of the state medical examining boards. Now such endorsement is possible with all but Maine, where the statutes make such action illegal at present. Now a physician licensed in Connecticut, a graduate of a class A school, and able to meet all other educational and moral requirements of neighboring Rhode Island and Massachusetts, may qualify for licensure in those states by endorsement and without the necessity of passing written tests as required by the basic science and the medical examining boards of physicians making applications for initial licensure.

State Lines Overlooked

While state boundary lines may be vitally important to government officials, they mean little to the people of New England, particularly in the ques-

continued on page 903

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AS IT LOOKS FROM NEW ENGLAND

concluded from page 900

tion of medical and hospital care. Physicians in larger cities near neighboring states find many of their patients to be nonresidents. Thus, in Rhode Island we find patients coming to Pawtucket and Providence from nearby Massachusetts towns, and at the same time some Rhode Islanders going to Boston, 44 miles away, or, in the Newport County area, to nearby Fall River, 5 miles away, for hospitalization. The same situation exists in the other states, and New Hampshire and Vermont have even found it advantageous to have one hospitalization and one medical care program to encompass both states.

This situation has prompted the council to explore the provisions for extending medical care through voluntary insurance programs, and it is interesting to note the diversity of plans in such a compact region. All but Maine have passed enabling legislation to permit the formation of a nonprofit corporation to provide prepaid surgical insurance. Massachusetts and New Hampshire have developed successful programs with the Blue Cross as the merchandising agent, and Vermont has now affiliated with the New Hampshire program. Connecticut and Rhode Island are completing studies calling for the utilization of private insurance carriers along the lines developed by Wisconsin.

Thus the area may become a testing ground to determine the comparable advantages and disadvantages of the two insurance programs for extending medical service on a voluntary basis. This diversity in thinking and planning in one compact area is certain to result in comparative studies in the future that will have important bearings on the development of plans in other parts of the country.

Accomplishments of the Council

The pattern of the Council of the New England State Medical Societies may well be copied by other areas to their advantage. The council has served successfully as an informative bureau for the officers of the state societies and as a discussion conference at which area problems receive careful and deliberative study. Within the past two years the council has explored such subjects as the medical needs of the veterans and of the physician veterans, medical public relations, industrial health, medical needs of rural communities, maternal and infant care, hospital survey, and the position of hospitals in the postwar world, medical licensure, group practice in the small community, and approaches to the national health question.

Certainly no region has taken more definite and progressive action in acquainting the officers of the state medical societies in its area with the attitudes, the decisions, and the plans of the medical profession in the neighboring states than has New England.—JOHN E. FARRELL

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